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COMPILATION
OF THE
SOCIAL SECURITY LAWS

INCLUDING THE SOCIAL SECURITY ACT,
AS AMENDED, AND RELATED ENACTMENTS
THROUGH JANUARY 1, 1991

VOLUME I

PRINTED FOR THE USE OF THE
COMMITTEE ON WAYS AND MEANS BY ITS STAFF

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PREFACE

The Social Security Act

The original Social Security Act is P.L. 74-271 (49 Stat. 620), approved August 14, 1935. The Social Security Act has been amended, in part, a number of times. A list of the laws amending the Social Security Act is in Appendix I, Volume II.

Administration of the Social Security Act

The Social Security Board was responsible for administration of the original Social Security Act except for parts 1, 2, 3, and 5 of Title V (which were administered by the Children's Bureau, then in the Department of Labor); part 4 of Title V which increased the appropriations authorized for carrying out the Act of June 2, 1920 (now see Rehabilitation Act of 1973); and Title VI which authorized grants to the States for public health work.

The Social Security Board was transferred to the Federal Security Agency by Reorganization Plan No. 1 of 1939 and the Board's functions were thenceforth to be carried on under the direction and supervision of the Federal Security Administrator. Reorganization Plan No. 2 of 1946 [see Vol. II] transferred the functions of the Social Security Board, as well as the functions of the Children's Bureau and the functions of the Secretary of Labor under Title V of the Social Security Act, to the Federal Security Administrator and the Board was abolished.

The Bureau of Employment Security, with its unemployment compensation and employment service functions, was transferred from the Federal Security Agency to the Department of Labor by Reorganization Plan No. 2 of 1949 [see Vol. II].

The Department of Health, Education, and Welfare was established by Reorganization Plan No. 1 of 1953 [see Vol. II] with a Secretary of Health, Education, and Welfare as the head of the Department. All functions of the Federal Security Agency, which was abolished, were transferred to the Department of Health, Education, and Welfare. The functions of the Federal Security Administrator were transferred to the Secretary of Health, Education, and Welfare.

The Department of Health, Education, and Welfare was redesignated the Department of Health and Human Services, and the Secretary of Health, Education, and Welfare was redesignated the Secretary of Health and Human Services by P.L. 96-88, §509, approved October 17, 1979. That public law did not amend references to the Secretary in the Social Security Act. The Department of Health and Human Services redesignation was effective May 4, 1980 (45 Federal Register 29642; May 5, 1980). The Department of Education which was established by P.L. 96-88 was activated May 4, 1980 (Executive Order 12212 of May 2, 1980; 45 Federal Register 29557; May 5, 1980).

This Compilation of the Social Security Laws

This compilation is current through January 1, 1991. This compilation contains:

Volume I

(1) Table of Contents;
(2) The Social Security Act, as in effect January 1, 1991;
(3) Internal Revenue Code—Selected Provisions; and
(4) Index to the Social Security Act.

Volume II

(1) Table of Contents;

(2) Other provisions of the Internal Revenue Code, provisions of public laws and statutes which are cited in the Social Security Act, and provisions of public laws which affect administration of the Social Security Act but do not amend it; and

(3) Appendixes containing other helpful information.

Volume III

Provisions of the Social Security Act which have been superseded.

Effect of Compilation

This Compilation of the Social Security Laws is not prima facie evidence of the provisions of the Social Security Act or other laws or statutes which are included. This compilation has been prepared solely for convenient reference purposes.

Cautions

Although they are not a part of the text of the law, citations have been included which will enable the reader to locate the same material in the United States Code (U.S.C.). These matching citations to the United States Code are shown within brackets after the public law section, as, for example:

[Social Security Act**]**	Sec. 201. **[**42 U.S.C. 401**]**
[Public Law 99-509**]**	Sec. 9342. **[**42 U.S.C. 1395b-1 note**]**.

Thus, both sections may be found in Title 42 of the United States Code, the first at section 401 and the second in the notes following section 1395b-1. "**[**None assigned**]**" means the provision is not in the United States Code, but can be found in the public law.

COMPILED BY

THE SOCIAL SECURITY ADMINISTRATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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[1] This table of contents does not appear in the law.

SOCIAL SECURITY ACT[1]

(As Amended through January 1, 1991)

AN ACT

To provide for the general welfare by establishing a system of Federal old-age benefits, and by enabling the several States to make more adequate provision for aged persons, blind persons, dependent and crippled children, maternal and child welfare, public health, and the administration of their unemployment compensation laws; to establish a Social Security Board; to raise revenue; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

[TITLE I—GRANTS TO STATES FOR OLD-AGE ASSISTANCE FOR THE AGED][2]

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APPROPRIATION

SECTION 1. [42 U.S.C. 301] For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish financial assistance to aged needy individuals, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare[4] (hereinafter referred to as the "Secretary"), State plans for old-age assistance.

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[1] P.L. 74-271, approved August 14, 1935, 49 Stat. 620.

[2] Title I of the Social Security Act is administered by the Department of Health and Human Services (formerly the Department of Health, Education, and Welfare). The Office of Family Assistance, Social Security Administration, administers benefit payments under Title I. The Administration for Public Services, Office of Human Development Services, administers social services under Title I.

Title I appears in the United States Code as §§301-306, subchapter I, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services relating to Title I are contained in subtitle A and chapter XIII, Title 45, Code of Federal Regulations.

P.L. 92-603, §303, *repealed* Title I effective January 1, 1974, *except* with respect to Puerto Rico, Guam, and the Virgin Islands. The Commonwealth of the Northern Marianas may elect to initiate a Title I social services program if it chooses; see Vol. II, P.L. 94-241, approved March 24, 1976, 90 Stat. 263, [Covenant to Establish Northern Mariana Islands].

See Vol. II, 31 U.S.C. 6504-6505, with respect to intergovernmental cooperation.

See Vol. II, 31 U.S.C. 7501-7507, with respect to uniform audit requirements for State and local governments receiving Federal financial assistance.

See Vol. II, P.L. 82-183, §618, for the "Jenner Amendment", which prohibits denial of grants-in-aid under certain conditions.

See Vol. II, P.L. 88-352, §601, for prohibition against discrimination in Federally assisted programs.

See Vol. II, P.L. 89-97, §121(b), with respect to restrictions on payment to a State receiving payments under Title XIX.

See Vol. II, P.L. 90-248, §234(c), with respect to nursing homes which do not meet all requirements of a State for licensure.

See Vol. II, P.L. 95-521, §102(i), with respect to reporting of benefits received under the Social Security Act.

[3] This table of contents does not appear in the law.

STATE OLD-AGE PLANS

SEC. 2. [42 U.S.C. 302] (a) A State plan for old-age assistance must—

(1) except to the extent permitted by the Secretary with respect to services, provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State;

(3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan;

(4) provide (A) for granting an opportunity for a fair hearing before the State agency to any individual whose claim for assistance under the plan is denied or is not acted upon with reasonable promptness, and (B) that if the State plan is administered in each of the political subdivisions of the State by a local agency and such local agency provides a hearing at which evidence may be presented prior to a hearing before the State agency, such local agency may put into effect immediately upon issuance its decision upon the matter considered at such hearing;

(5) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary[5] to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

---

[4] This is deemed to refer, effective on May 4, 1980, to the Secretary of Health and Human Services under section 509(a) of the "Department of Education Organization Act" (P.L. 96-88, 93 Stat. 695).

[5] P.L. 91-648, §208(a)(3)(D), transferred to the U.S. Civil Service Commission, effective March 6, 1971, all powers, functions, and duties of the Secretary under subparagraph (A). Functions of the Commission were transferred, effective January 1, 1979, to the Director of the Office of Personnel Management by section 102 of Reorganization Plan No. 2 of 1978.

(7) provide safeguards which permit the use or disclosure of information concerning applicants or recipients only (A) to public officials who require such information in connection with their official duties, or (B) to other persons for purposes directly connected with the administration of the State plan;

(8) provide that all individuals wishing to make application for assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide, if the plan includes assistance for or on behalf of individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions;

(10) if the State plan includes old-age assistance—

(A) provide that the State agency shall, in determining need for such assistance, take into consideration any other income and resources of an individual claiming old-age assistance, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination, (i) the State agency may disregard not more than $7.50 per month of any income and (ii) of the first $80 per month of additional income which is earned the State agency may disregard not more than the first $20 thereof plus one-half of the remainder;[6]

(B) include reasonable standards, consistent with the objectives of this title, for determining eligibility for and the extent of such assistance; and

(C) provide a description of the services (if any) which the State agency makes available (using whatever internal organizational arrangement it finds appropriate for this purpose) to applicants for and recipients of such assistance to help them attain self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services; and

---

[6] See Vol. II, 10 U.S.C. 2546, with respect to shelter for the homeless at military installations.

See Vol. II, P.L. 81-171, §521(a)(1)(E), with respect to exclusion from income and resources of certain assistance rendered to provide occupant-owned, rental and cooperative housing.

See Vol. II, P.L. 87-543, §141(b), with respect to ineligibility to receive payments under Title I where payments have been made under Title XVI.

See Vol. II, P.L. 88-525, §8(b), with respect to exclusion from income and resources of the value of food stamps.

See Vol II, P.L. 89-73, §210(b), with respect to exclusion from income of the costs of any project under any title of that Act.

See Vol. II, P.L. 90-248, §248(c), effective July 1, 1969, with respect to income disregards applicable to Guam, Puerto Rico, and the Virgin Islands.

See Vol. II, P.L. 91-646, §216, with respect to exclusion from income of payments made under that act.

See Vol. II, P.L. 93-113, §404(g), with respect to exclusion from income and resources of payments to volunteers under that act.

See Vol. II, P.L 95-557, §410(b), with respect to exclusion from income of services provided to a public housing resident or to a resident of a housing project assisted under the "Housing Act of 1959" (see Vol. II, P.L. 86-372, §202.).

See Vol. II, P.L. 101-41, "Puyallup Tribe of Indians Settlement Act of 1989", §10(b) - (d), with respect to eligibility for Federal programs and treatment of funds, assets, and income.

See P.L. Vol. II, 101-42, "Coquille Restoration Act", §3, with respect to the restoration of Federal recognition, rights, and privileges.

See P.L. Vol. II, 101-201, with respect to Agent Orange settlement payments.

See Vol. II, P.L. 101-239, §10405, with respect to Agent Orange settlement payments excluded from countable income and resources under Federal means-tested programs.

See Vol. II, P.L. 101-277, §8(b), with respect to exclusion, from income or resources, of funds held in trust or distribution to Seminole Indians.

(11) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act.

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for assistance under the plan—

(1) an age requirement of more than sixty-five years; or

(2) any residence requirement which (A) in the case of applicants for old-age assistance, excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for old-age assistance and has resided therein continuously for one year immediately preceding the application, and (B) in the case of applicants for medical assistance for the aged, excludes any individual who resides in the State; or

(3) any citizenship requirement which excludes any citizen of the United States.

At the option of the State, the plan may provide that manuals and other policy issuances will be furnished to persons without charge for the reasonable cost of such materials, but such provision shall not be required by the Secretary as a condition for the approval of such plan under this title.

(c) Nothing in this title shall be construed to permit a State to have in effect with respect to any period more than one State plan approved under this title.

PAYMENT TO STATES

SEC. 3. [42 U.S.C. 303] (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing October 1, 1960—

[(1) Stricken.[7]]

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as old-age assistance under the State plan, not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of old-age assistance for such month; plus

[(3) Stricken.[8]]

(4) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and efficient administration of the State plan—

(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

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[7] P.L. 97-35, §2184(a)(4)(A); 95 Stat. 816.
[8] P.L. 97-35, §2184(a)(4)(A); 95 Stat. 816.

(B) 100 percent of so much of such expenditures as are for the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus

(C) one-half of the remainder of such expenditures.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Health, Education, and Welfare shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of aged individuals in the State, and (C) such other investigation as the Secretary may find necessary.

(2) The Secretary of Health, Education, and Welfare shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health, Education, and Welfare, (A) reduced or increased, as the case may be, by any sum by which he finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Secretary of Health, Education, and Welfare, of the net amount recovered during any prior quarter by the State or any political subdivision thereof with respect to assistance furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary for such prior quarter: *Provided,* That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause (B) of this paragraph.

(3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement[9] of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Health, Education, and Welfare, the amount so certified.

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[9] As in original.

OPERATION OF STATE PLANS

SEC. 4. [42 U.S.C. 304] In the case of any State plan which has been approved under this title by the Secretary of Health, Education, and Welfare, if the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds—

(1) that the plan has been so changed as to impose any age, residence, or citizenship requirement prohibited by section 2(b), or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or

(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 2(a) to be included in the plan;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) until the Secretary is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

[SEC. 5. Repealed.[10]]

DEFINITION[11]

SEC. 6. [42 U.S.C. 306] (a)[12] For the purposes of this title, the term "old-age assistance" means money payments to, or (if provided in or after the third month before the month in which the recipient makes application for assistance) medical care in behalf of or any type of remedial care recognized under State law in behalf of, needy individuals who are 65 years of age or older, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution). Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 2 includes provision for—

(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such assistance through payments described in this sentence;

---

[10] P.L. 92-603, §303(a); 86 Stat. 1484.

The P.L. 92-603, §303(b), repeal exception is deemed not applicable to §5 because it was executed with expenditure of the appropriation for the fiscal year ending June 30, 1936, and never became applicable to Puerto Rico, Guam, or the Virgin Islands.

[11] As in original. P.L. 86-778, §601(f)(2), [74 Stat. 991], did not amend the catchline.

[12] As in original; "(a)" should be stricken.

(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of old-age assistance to be paid (and in conjunction with other income and resources), meet all the need[13] of the individuals with respect to whom such payments are made;

(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made.

At the option of a State (if its plan approved under this title so provides), such term (i) need not include money payments to an individual who has been absent from such State for a period in excess of 90 consecutive days (regardless of whether he has maintained his residence in such State during such period) until he has been present in such State for 30 consecutive days in the case of such an individual who has maintained his residence in such State during such period or 90 consecutive days in the case of any other such individual, and (ii) may include rent payments made directly to a public housing agency on behalf of a recipient or a group or groups of recipients of assistance under such plan.

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[13] As in original. Should be "needs".

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS[1]

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[1] Title II of the Social Security Act is administered by the Social Security Administration, Department of Health and Human Services (formerly the Department of Health, Education, and Welfare). Title II appears in the United States Code as §§401-433, subchapter II, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services relating to Title II are contained in chapter III, Title 20, Code of Federal Regulations.

See Vol. II, 31 U.S.C. 3720 and 3720A with respect to collection of payments due to Federal agencies; and §3803(c)(2)(C) with respect to benefits not affected by P.L. 100-383.

See Vol. II, P.L. 94-566, §503, with respect to preservation of medicaid eligibility for individuals who cease to be eligible for supplemental security income benefits on account of cost-of-living increases in social security benefits.

See Vol. II, P.L. 95-521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 95-608, §§201-204, with respect to Indian child and family programs.

See Vol. II, P.L. 96-265, §505, as amended by P.L. 101-239, with respect to authority for demonstration projects.

See Vol. II, P.L. 98-4, §3(b)(4), with respect to the treatment of agricultural commodities received under a 1983 payment-in-kind program.

See Vol. II, P.L. 98-21, §101(e), with respect to the effect of amendments made by that law on benefits under the Federal Retirement System; and §310(b), with respect to validity of payments made, before April 20, 1983, as a result of a judicial determination.

See Vol. II, P.L. 99-190, §130, with respect to provisions applicable to the position of Chief of the U.S. Capitol Police.

See Vol. II, P.L. 100-203, §9021, with respect to the moratorium on reductions in attorneys' fees and studies of attorneys' fee payment system; and §9402(b), with respect to clarification of congressional intent as to scope of 31 U.S.C. 3720A.

See Vol. II, P.L. 100-204, §724(d), with respect to furnishing information to the United States Commission on Improving the Effectiveness of the United Nations; and §725(b), with respect to the detailing of Government personnel.

See Vol. II, P.L. 100-235, §§5-8, with respect to responsibilities of each Federal agency for computer systems security and privacy.

See Vol. II, P.L. 100-383, §§105(f)(2) and 206(d)(2), with respect to exclusion from income and resources of certain payments to certain individuals.

See Vol. II, P.L. 100-647, §8019, with respect to reports regarding certain disability-related benefits.

See Vol. II, P.L. 100-690, §5301(a)(1)(C) and (d)(1)(B), with respect to benefits of drug traffickers and possessors.

See Vol. II, P.L. 101-239, §10202(a), (d) and (e), with respect to refunds from employers to compensate for duplication of Medicare benefits.

See Vol. II, P.L. 101-508, §5103(e)(2), with respect to application requirements for certain individuals on benefit rolls; §5105(b)(3), with respect to demonstration projects relating to the provision of information to local agencies providing child and adult protective services; §5105(d)(3), with respect to a study to be conducted by the Secretary regarding involvement of the Department of Veterans Affairs; and §§13301 and 13302, with respect to OASDI Trust Funds.

[2] This table of contents does not appear in the law.

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FEDERAL OLD-AGE AND SURVIVORS INSURANCE TRUST FUND AND FEDERAL DISABILITY INSURANCE TRUST FUND[3]

SECTION 201. [42 U.S.C. 401] (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Old-Age and Survivors Insurance Trust Fund". The Federal Old-Age and Survivors Insurance Trust Fund shall consist of the securities held by the Secretary of the Treasury for the Old-Age Reserve Account and the amount standing to the credit of the Old-Age Reserve Account on the books of the Treasury on January 1, 1940, which securities and amount the Secretary of the Treasury is authorized and directed to transfer to the Federal Old-Age and Survivors Insurance Trust Fund, and, in addition, such gifts and bequests as may be made as provided in subsection (i)(1), and such amounts as may be appropriated to, or deposited in, the Federal Old-Age and Survivors Insurance Trust Fund as hereinafter provided. There is hereby appropriated to the Federal Old-Age and Survivors Insurance Trust Fund for the fiscal year ending June 30, 1941, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

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[3] See Vol. II, 14 U.S.C. 707(e)(3) with respect to the requirement for certification to the Secretary of Labor of an individual's insured status.

See Vol. II, P.L. 95-250, §201(19), with respect to trust fund contributions and §204(b)(4), with respect to Title XVIII ineligibility.

See Vol. II, P.L. 98-21, §121(e), with respect to transfers of funds from the Secretary of the Treasury to the Trust Fund.

See Vol. II, P.L. 98-168, §§201-208, with respect to certain Federal employees covered under both the Social Security Act and a Federal retirement system.

(1) the taxes (including interest, penalties, and additions to the taxes) received under subchapter A of chapter 9 of the Internal Revenue Code of 1939[4] (and covered into the Treasury) which are deposited into the Treasury by collectors of internal revenue before January 1, 1951; and

(2) the taxes certified each month by the Commissioner of Internal Revenue as taxes received under subchapter A of chapter 9 of such Code which are deposited into the Treasury by collectors of internal revenue after December 31, 1950, and before January 1, 1953, with respect to assessments of such taxes made before January 1, 1951; and

(3) the taxes imposed by subchapter A of chapter 9 of such Code with respect to wages (as defined in section 1426 of such Code), and by chapter 21 (other than sections 3101(b) and 3111(b)) of the Internal Revenue Code of 1954[5] with respect to wages (as defined in section 3121 of such Code[6]) reported to the Commissioner of Internal Revenue pursuant to section 1420(c) of the Internal Revenue Code of 1939 after December 31, 1950, or to the Secretary of the Treasury or his delegates pursuant to subtitle F of the Internal Revenue Code of 1954[7] after December 31, 1954, as determined by the Secretary of the Treasury by applying the applicable rates of tax under such subchapter or chapter 21 (other than sections 3101(b) and 3111(b)) to such wages, which wages shall be certified by the Secretary of Health and Human Services on the basis of the records of wages established and maintained by such Secretary in accordance with such reports, less the amounts specified in clause (1) of subsection (b) of this section; and

(4) the taxes imposed by subchapter E of chapter 1 of the Internal Revenue Code of 1939, with respect to self-employment income (as defined in section 481 of such Code), and by chapter 2 (other than section 1401(b)) of the Internal Revenue Code of 1954[8] with respect to self-employment income (as defined in section 1402 of such Code[9]) reported to the Commissioner of Internal Revenue on tax returns under such subchapter or to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such subchapter or chapter (other than section 1401(b)) to such self-employment income, which self-employment income shall be certified by the Secretary of Health and Human Services on the

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[4] P.L. 76-1.

[5] See P.L. 83-591, chapter 21, (this volume).

[6] See P.L. 83-591, §3121, (this volume).

[7] P.L. 83-591.

P.L. 99-514, §2, provides, except when inappropriate, any reference to the Internal Revenue Code of 1954 shall include a reference to the Internal Revenue Code of 1986.

[8] See P.L. 83-591, chapter 2, (this volume).

[9] See P.L. 83-591, §1402, (this volume).

basis of the records of self-employment income established and maintained by the Secretary of Health and Human Services in accordance with such returns, less the amounts specified in clause (2) of subsection (b) of this section.

The amounts appropriated by clauses (3) and (4) shall be transferred from time to time[10] from the general fund in the Treasury to the Federal Old-Age and Survivors Insurance Trust Fund, and the amounts appropriated by clauses (1) and (2) of subsection (b) shall be transferred from time to time[11] from the general fund in the Treasury to the Federal Disability Insurance Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in clauses (3) and (4) of this subsection, paid to or deposited into the Treasury[12]; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such clauses (3) and (4) of this subsection. All amounts transferred to either Trust Fund under the preceding sentence shall be invested by the Managing Trustee in the same manner and to the same extent as the other assets of such Trust Fund. Notwithstanding the preceding sentence, in any case in which the Secretary of the Treasury determines that the assets of either such Trust Fund would otherwise be inadequate to meet such Fund's obligations for any month, the Secretary of the Treasury shall transfer to such Trust Fund on the first day of such month the amount which would have been transferred to such Fund under this section as in effect on October 1, 1990; and[13] and such Trust Fund shall pay interest to the general fund on the amount so transferred on the first day of any month at a rate (calculated on a daily basis, and applied against the difference between the amount so transferred on such first day and the amount which would have been transferred to the Trust Fund up to that day under the procedures in effect on January 1, 1983) equal to the rate earned by the investments of such Fund in the same month under subsection (d).

(b) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Disability Insurance Trust Fund". The Federal Disability Insurance Trust Fund shall consist of such gifts and bequests as may be made as provided in subsection (i)(1), and such amounts as may be appropriated to, or deposited in, such fund as provided in this section. There is hereby appropriated to the Federal Disability Insurance Trust Fund for the fiscal year ending June 30, 1957, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1)(A) 1/2 of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954[14]) paid after December 31, 1956, and before January 1, 1966, and reported to the

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[10] P.L. 101-508, §5115(a)(1)(A), struck out "monthly on the first day of each calendar month" and substituted "from time to time", effective December 1, 1990.

[11] P.L. 101-508, §5115(a)(1)(A), struck out "monthly on the first day of each calendar month" and substituted "from time to time", effective December 1, 1990.

[12] P.L. 101-508, §5115(a)(1)(B), struck out "to be paid to or deposited into the Treasury during such month" and substituted "paid to or deposited into the Treasury", effective December 1, 1990.

[13] P.L. 101-508, §5115(a)(2), struck out "Fund;" and substituted "Fund. Notwithstanding the preceding sentence, in any case in which the Secretary of the Treasury determines that the assets of either such Trust Fund would otherwise be inadequate to meet such Fund's obligations for any month, the Secretary of the Treasury shall transfer to such Trust Fund on the first day of such month the amount which would have been transferred to such Fund under this section as in effect on October 1, 1990; and", effective December 1, 1990. One "and" should be deleted.

[14] See P.L. 83-591, §3121; (this volume).

Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, (B) 0.70 of 1 per centum of the wages (as so defined) paid after December 31, 1965, and before January 1, 1968, and so reported, (C) 0.95 of 1 per centum of the wages (as so defined) paid after December 31, 1967, and before January 1, 1970, and so reported, (D) 1.10 per centum of the wages (as so defined) paid after December 31, 1969, and before January 1, 1973, and so reported, (E) 1.1 per centum of the wages (as so defined) paid after December 31, 1972, and before January 1, 1974, and so reported, (F) 1.15 per centum of the wages (as so defined) paid after December 31, 1973, and before January 1, 1978, and so reported, (G) 1.55 per centum of the wages (as so defined) paid after December 31, 1977, and before January 1, 1979, and so reported, (H) 1.50 per centum of the wages (as so defined) paid after December 31, 1978, and before January 1, 1980, and so reported, (I) 1.12 per centum of the wages (as so defined) paid after December 31, 1979, and before January 1, 1981, and so reported, (J) 1.30 per centum of the wages (as so defined) paid after December 31, 1980, and before January 1, 1982, and so reported, (K) 1.65 per centum of the wages (as so defined) paid after December 31, 1981, and before January 1, 1983, and so reported, (L) 1.25 per centum of the wages (as so defined) paid after December 31, 1982, and before January 1, 1984, and so reported, (M) 1.00 per centum of the wages (as so defined) paid after December 31, 1983, and before January 1, 1988, and so reported, (N) 1.06 per centum of the wages (as so defined) paid after December 31, 1987, and before January 1, 1990, and so reported, (O) 1.20 per centum of the wages (as so defined) paid after December 31, 1989, and before January 1, 2000, and so reported, and (P) 1.42 per centum of the wages (as so defined) paid after December 31, 1999, and so reported, which wages shall be certified by the Secretary of Health and Human Services on the basis of the records of wages established and maintained by such Secretary in accordance with such reports; and

(2)(A) 3/8 of 1 per centum of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1954[15]) reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of the Internal Revenue Code of 1954[16] for any taxable year beginning after December 31, 1956, and before January 1, 1966, (B) 0.525 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1965, and before January 1, 1968, (C) 0.7125 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1967, and before January 1, 1970, (D) 0.825 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1969, and before January 1, 1973, (E) 0.795 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1972, and before January 1, 1974, (F) 0.815 of 1 per centum of the amount of self-employment income (as so defined) as reported for any taxable year beginning after December 31, 1973, and before January 1, 1978, (G) 1.090 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1977, and before January 1, 1979, (H) 1.0400 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1978, and before January 1, 1980, (I) 0.7775 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1979, and before January 1, 1981, (J) 0.9750 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1980, and before January 1, 1982, (K) 1.2375 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1981, and before January 1, 1983, (L) 0.9375 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1982, and before January 1, 1984, (M) 1.00 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1983, and before January 1, 1988, (N) 1.06 per centum of the self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1987, and before January 1, 1990, (O) 1.20 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1989, and before January 1, 2000, and (P) 1.42 per centum of the self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1999, which self-employment income shall be certified by the Secretary of Health and Human Services on the basis of the records of self-employment income established and maintained by the Secretary of Health and Human Services in accordance with such returns.

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[15] See P.L. 83-591, §1402; (this volume).

[16] P.L. 83-591.

(c) With respect to the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund (hereinafter in this title called the "Trust Funds") there is hereby created a body to be known as the Board of Trustees of the Trust Funds (hereinafter in this title called the "Board of Trustees") which Board of Trustees shall be composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this title called the "Managing Trustee"). The Commissioner of Social Security shall serve as Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Funds;

(2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Funds during the preceding fiscal year and on their expected operation and status during the next ensuing five fiscal years;

(3) Report immediately to the Congress whenever the Board of Trustees is of the opinion that the amount of either of the Trust Funds is unduly small;

(4) Recommend improvements in administrative procedures and policies designed to effectuate the proper coordination of the old-age and survivors insurance and Federal-State unemployment compensation program; and

(5) Review the general policies followed in managing the Trust Funds, and recommend changes in such policies, including necessary changes in the provisions of the law which govern the way in which the Trust Funds are to be managed.

The report provided for in paragraph (2) above shall include a statement of the assets of, and the disbursements made from, the Trust Funds during the preceding fiscal year, an estimate of the expected future income to, and disbursements to be made from, the Trust Funds during each of the next ensuing five fiscal years, and a statement of the actuarial status of the Trust Funds. Such statement shall include a finding by the Board of Trustees as to whether the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, individually and collectively, are in close actuarial balance (as defined by the Board of Trustees).[17] Such report shall include an an actuarial opinion by the Chief Actuary of the Social Security Administration certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable. Such report shall also include an actuarial analysis of the benefit disbursements made from the Federal Old-Age and Survivors Insurance Trust Fund with respect to disabled beneficiaries. Such report shall be printed as a House document of the session of the Congress to which the report is made. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Funds.

(d) It shall be the duty of the Managing Trustee to invest such portion of the Trust Funds as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United

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[17] P.L. 101-508, §13304, added this sentence, effective for annual reports of the Board of Trustees issued in or after calendar year 1991.

States may be issued under chapter 31 of title 31, United States Code, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Funds. Such obligations issued for purchase by the Trust Funds shall have maturities fixed with due regard for the needs of the Trust Funds and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of four years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest of such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.[18]

(e) Any obligations acquired by the Trust Funds (except public-debt obligations issued exclusively to the Trust Funds) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(f) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund shall be credited to and form a part of the Federal Old-Age and Survivors Insurance Trust Fund and the Disability Insurance Trust Fund, respectively.

(g)(1)(A) The Managing Trustee of the Trust Funds (which for purposes of this paragraph shall include also the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund[19] established by title XVIII) is directed to pay from the Trust Funds into the Treasury—

(i) the amounts estimated by him and the Secretary of Health and Human Services which will be expended, out of moneys appropriated from the general fund in the Treasury, during a three-month period by the Department of Health and Human Services and the Treasury Department for the administration of titles II, XVI, and XVIII of this Act and subchapter E of chapter 1 and subchapter A of chapter 9 of the Internal Revenue Code of 1939[20], and chapters 2 and 21 of the Internal Revenue Code of 1954[21], less

(ii) the amounts estimated (pursuant to the method prescribed by the Board of Trustees under paragraph (4) of this subsection) by the Secretary of Health and Human Services which will be expended, out of moneys made available for expenditures from the Trust Funds, during such three-month period to cover the cost of carrying out the functions of the Department of Health and Human Services, specified in section 232, which relate to the administration of provisions of the Internal Revenue Code of 1954[22] other than those referred to in clause (i).[23]

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[18] See Vol. II, P.L. 100-203, §9401, with respect to the restoration of trust funds for 1987.

[19] P.L. 101-234, §202(a), struck out ", Federal Supplementary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund" and substituted "and the Federal Supplementary Medical Insurance Trust Fund", effective January 1, 1990.

[20] P.L. 76-1.

[21] See P.L. 83-591, §1402, (this volume).

Such payments shall be carried into the Treasury as the net amount of repayments due the general fund account for reimbursement of expenses incurred in connection with the administration of titles II, XVI, and XVIII of this Act and subchapter E of chapter 1 and subchapter A of chapter 9 of the Internal Revenue Code of 1939, and chapters 2 and 21 of the Internal Revenue Code of 1954[24]. A final accounting of such payments for any fiscal year shall be made at the earliest practicable date after the close thereof. There are hereby authorized to be made available for expenditure, out of any or all of the Trust Funds, such amounts as the Congress may deem appropriate to pay the costs of the part of the administration of this title, title XVI, and title XVIII for which the Secretary of Health and Human Services is responsible and of carrying out the functions of the Department of Health and Human Services, specified in section 232, which relate to the administration of provisions of the Internal Revenue Code of 1954 other than those referred to in clause (i) of the first sentence of this subparagraph.[25]

(B) After the close of each fiscal year the Secretary of Health and Human Services shall determine the portion of the costs, incurred during such fiscal year, of administration of this title, title XVI, and title XVIII and of carrying out the functions of the Department of Health and Human Services, specified in section 232, which relate to the administration of provisions of the Internal Revenue Code of 1954 (other than those referred to in clause (i) of the first sentence of subparagraph (A)), which should have been borne by the general fund in the Treasury and the portion of such costs which should have been borne by each of the Trust Funds; except that the determination of the amounts to be borne by the general fund in the Treasury with respect to expenditures incurred in carrying out such functions specified in section 232 shall be made pursuant to the method prescribed by the Board of Trustees under paragraph (4) of this subsection. After such determination has been made, the Secretary of Health and Human Services shall certify to the Managing Trustee the amounts, if any, which should be transferred from one to any of the other of such Trust Funds and the amounts, if any, which should be transferred between the Trust Funds (or one of the Trust Funds) and the general fund in the Treasury, in order to insure that each of the Trust Funds and the general fund in the Treasury have borne their proper share of the costs, incurred during such fiscal year, for the part of the administration of this title, title XVI, and title XVIII for which the Secretary of Health and Human Services is responsible and of carrying out the functions of the Department of Health and Human Services, specified in section 232, which relate to the administration of provisions of the Internal Revenue Code of 1954 (other than those referred to in clause (i) of the first sentence of subparagraph (A)). The Managing Trustee is authorized and directed to transfer any such amounts in accordance with any certification so made.

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[22] P.L. 83-591.

[23] See Vol. II, P.L. 94-202, §8(f), with respect to making the estimates required under this clause.

[24] See P.L. 83-591, chapter 2, (this volume).

[25] See Vol. II, P.L. 92-603, §305(b), with respect to repayment of expenditures made from OASI Trust Funds for costs of administration of Title XVI of the Act.

(2) The Managing Trustee is directed to pay from time to time from the Trust Funds into the Treasury the amount estimated by him as taxes imposed under section 3101(a) which are subject to refund under section 6413(c) of the Internal Revenue Code of 1954[26] with respect to wages (as defined in section 1426 of the Internal Revenue Code of 1939[27] and section 3121 of the Internal Revenue Code of 1954[28]) paid after December 31, 1950. Such taxes shall be determined on the basis of the records of wages established and maintained by the Secretary of Health and Human Services in accordance with the wages reported to the Commissioner of Internal Revenue pursuant to section 1420(c) of the Internal Revenue Code of 1939 and to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, and the Secretary shall furnish the Managing Trustee such information as may be required by the Trustee for such purpose. The payments by the Managing Trustee shall be covered into the Treasury as repayments to the account for refunding internal revenue collections. Payments pursuant to the first sentence of this paragraph shall be made from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund in the ratio in which amounts were appropriated to such Trust Funds under clause (3) of subsection (a) of this section and clause (1) of subsection (b) of this section.

(3) Repayments made under paragraph (1) or (2) shall not be available for expenditures but shall be carried to the surplus fund of the Treasury. If it subsequently appears that the estimates under either such paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Managing Trustee in future payments.

(4) The Board of Trustees shall prescribe before January 1, 1981, the method of determining the costs which should be borne by the general fund in the Treasury of carrying out the functions of the Department of Health and Human Services, specified in section 232, which relate to the administration of provisions of the Internal Revenue Code of 1954 (other than those referred to in clause (i) of the first sentence of paragraph (1)(A)). If at any time or times thereafter the Boards of Trustees of such Trust Funds deem such action advisable they may modify the method so determined.[29]

(h) Benefit payments required to be made under section 223, and benefit payments required to be made under subsection (b), (c), or (d) of section 202 to individuals entitled to benefits on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits, shall be made only from the Federal Disability Insurance Trust Fund. All other benefit payments required to be made under this title (other than section 226) shall be made only from the Federal Old-Age and Survivors Insurance Trust Fund.

(i)(1) The Managing Trustee of the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust Fund[30] is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to any one or more of such Trust Funds or to the Department of Health and Human Services, or any part or officer thereof, for the benefit of any of such Funds or any activity financed through such Funds.[31]

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[26] See P.L. 83-591, §3101(a), (this volume).
[27] P.L. 76-1.
[28] See P.L. 83-591, §3121, (this volume).
[29] See Vol. II, P.L. 94-202, §8(e), with respect to employment of assistants.

(2) Any such gift accepted pursuant to the authority granted in paragraph (1) of this subsection shall be deposited in—

(A) the specific trust fund designated by the donor or

(B) if the donor has not so designated, the Federal Old-Age and Survivors Insurance Trust Fund.

(j) There are authorized to be made available for expenditure, out of the Federal Old-Age and Survivors Insurance Trust Fund, or the Federal Disability Insurance Trust Fund (as determined appropriate by the Secretary), such amounts as are required to pay travel expenses, either on an actual cost or commuted basis, to individuals for travel incident to medical examinations requested by the Secretary in connection with disability determinations under this title, and to parties, their representatives, and all reasonably necessary witnesses for travel within the United States (as defined in section 210(i)) to attend reconsideration interviews and proceedings before administrative law judges with respect to any determination under this title. The amount available under the preceding sentence for payment for air travel by any person shall not exceed the coach fare for air travel between the points involved unless the use of first-class accommodations is required (as determined under regulations of the Secretary) because of such person's health condition or the unavailability of alternative accommodations; and the amount available for payment for other travel by any person shall not exceed the cost of travel (between the points involved) by the most economical and expeditious means of transportation appropriate to such person's health condition, as specified in such regulations. The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount allowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding.[32]

(k) Expenditures made for experiments and demonstration projects under section 505(a) of the Social Security Disability Amendments of 1980[33] shall be made from the Federal Disability Insurance Trust Fund and the Federal Old-Age and Survivors Insurance Trust Fund, as determined appropriate by the Secretary.

(l)(1) If at any time prior to January 1988 the Managing Trustee determines that borrowing authorized under this subsection is appropriate in order to best meet the need for financing the benefit payments from the Federal Old-Age and Survivors Insurance Trust

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[30] P.L 101-234, §202(a), struck out ", Federal Hospital Insurance Catastrophic Coverage Reserve Fund, Federal Supplementary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund" and substituted "and the Federal Supplementary Medical Insurance Trust Fund", effective January 1, 1990.

[31] See Vol. II, P.L. 92-603, §132(g), with respect to tax treatment of gifts or bequests to the Trust Funds.

[32] P.L. 101-508, §5106(c), added this sentence, applicable to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after April 1, 1991.

[33] See Vol. II, P.L. 96-265, §505(a), as amended by P.L. 101-239.

Fund or the Federal Disability Insurance Trust Fund, the Managing Trustee may borrow such amounts as he determines to be appropriate from the other such Trust Fund, or, subject to paragraph (5), from the Federal Hospital Insurance Trust Fund established under section 1817, for transfer to and deposit in the Trust Fund whose need for financing is involved.

(2) In any case where a loan has been made to a Trust Fund under paragraph (1), there shall be transferred on the last day of each month after such loan is made, from the borrowing Trust Fund to the lending Trust Fund, the total interest accrued to such day with respect to the unrepaid balance of such loan at a rate equal to the rate which the lending Trust Fund would earn on the amount involved if the loan were an investment under subsection (d) (even if such an investment would earn interest at a rate different than the rate earned by investments redeemed by the lending fund in order to make the loan).

(3)(A) If in any month after a loan has been made to a Trust Fund under paragraph (1), the Managing Trustee determines that the assets of such Trust Fund are sufficient to permit repayment of all or part of any loans made to such Fund under paragraph (1), he shall make such repayments as he determines to be appropriate.

(B)(i) If on the last day of any year after a loan has been made under paragraph (1) by the Federal Hospital Insurance Trust Fund to the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund, the Managing Trustee determines that the OASDI trust fund ratio exceeds 15 percent, he shall transfer from the borrowing Trust Fund to the Federal Hospital Insurance Trust Fund an amount that—

(I) together with any amounts transferred from another borrowing Trust Fund under this paragraph for such year, will reduce the OASDI trust fund ratio to 15 percent; and

(II) does not exceed the outstanding balance of such loan.

(ii) Amounts required to be transferred under clause (i) shall be transferred on the last day of the first month of the year succeeding the year in which the determination described in clause (i) is made.

(iii) For purposes of this subparagraph, the term "OASDI trust fund ratio" means, with respect to any calendar year, the ratio of—

(I) the combined balance in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, as of the last day of such calendar year, to

(II) the amount estimated by the Secretary to be the total amount to be paid from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund during the calendar year following such calendar year for all purposes authorized by section 201 (other than payments of interest on, and repayments of, loans from the Federal Hospital Insurance Trust Fund under paragraph (1), but excluding any transfer payments between such trust funds and reducing the amount of any transfer to the Railroad Retirement Account by the amount of any transfers into either such trust fund from that Account).

(C)(i) The full amount of all loans made under paragraph (1) (whether made before or after January 1, 1983) shall be repaid at the earliest feasible date and in any event no later than December 31, 1989.

(ii) For the period after December 31, 1987, and before January 1, 1990, the Managing Trustee shall transfer each month to the Federal Hospital Insurance Trust Fund from any Trust Fund with any amount outstanding on a loan made from the Federal Hospital Insurance Trust Fund under paragraph (1) an amount not less than an amount equal to (I) the amount owed to the Federal Hospital Insurance Trust Fund by such Trust Fund at the beginning of such month (plus the interest accrued on the outstanding balance of such loan during such month), divided by (II) the number of months elapsing after the preceding month and before January 1990. The Managing Trustee may, during this period, transfer larger amounts than prescribed by the preceding sentence.

(4) The Board of Trustees shall make a timely report to the Congress of any amounts transferred (including interest payments) under this subsection.

(5)(A) No amounts may be borrowed from the Federal Hospital Insurance Trust Fund under paragraph (1) during any month if the Hospital Insurance Trust Fund ratio for such month is less than 10 percent.

(B) For purposes of this paragraph, the term "Hospital Insurance Trust Fund ratio" means, with respect to any month, the ratio of—

(i) the balance in the Federal Hospital Insurance Trust Fund, reduced by the outstanding amount of any loan (including interest thereon) theretofore made to such Trust Fund under this subsection, as of the last day of the second month preceding such month, to

(ii) the amount obtained by multiplying by twelve the total amount which (as estimated by the Secretary) will be paid from the Federal Hospital Insurance Trust Fund during the month for which such ratio is to be determined (other than payments of interest on, or repayments of loans from another Trust Fund under this subsection), and reducing the amount of any transfers to the Railroad Retirement Account by the amount of any transfer into the Hospital Insurance Trust Fund from that Account.

(m)(1) The Secretary of the Treasury shall implement procedures to permit the identification of each check issued for benefits under this title that has not been presented for payment by the close of the sixth month following the month of its issuance.

(2) The Secretary of the Treasury shall, on a monthly basis, credit each of the Trust Funds for the amount of all benefit checks (including interest thereon) drawn on such Trust Fund more than 6 months previously but not presented for payment and not previously credited to such Trust Fund, to the extent provided in advance in appropriation Acts.

(3) If a benefit check is presented for payment to the Treasury and the amount thereof has been previously credited pursuant to paragraph (2) to one of the Trust Funds, the Secretary of the Treasury shall nevertheless pay such check, if otherwise proper, recharge such Trust Fund, and notify the Secretary of Health and Human Services.

(4) A benefit check bearing a current date may be issued to an individual who did not negotiate the original benefit check and who surrenders such check for cancellation if the Secretary of the Treasury determines it is necessary to effect proper payment of benefits.

OLD-AGE AND SURVIVORS INSURANCE BENEFIT PAYMENTS[34]

Old-Age Insurance Benefits

SEC. 202. [42 U.S.C. 402] (a) Every individual who—

(1) is a fully insured individual (as defined in section 214(a)),

(2) has attained age 62, and

(3) has filed application for old-age insurance benefits or was entitled to disability insurance benefits for the month preceding the month in which he attained retirement age (as defined in section 216(l)),

shall be entitled to an old-age insurance benefit for each month, beginning with—

(A) in the case of an individual who has attained retirement age (as defined in section 216(l)), the first month in which such individual meets the criteria specified in paragraphs (1), (2), and (3), or

(B) in the case of an individual who has attained age 62, but has not attained retirement age (as defined in section 216(l)), the first month throughout which such individual meets the criteria specified in paragraphs (1) and (2) (if in that month he meets the criterion specified in paragraph (3)),

and ending with the month preceding the month in which he dies. Except as provided in subsection (q) and subsection (w), such individual's old-age insurance benefit for any month shall be equal to his primary insurance amount (as defined in section 215(a)) for such month.

Wife's Insurance Benefits[35]

(b)(1) The wife (as defined in section 216(b)) and every divorced wife (as defined in section 216(d)) of an individual entitled to old-age or disability insurance benefits, if such wife or such divorced wife—

(A) has filed application for wife's insurance benefits,

(B) has attained age 62 or (in the case of a wife) has in her care (individually or jointly with such individual) at the time of filing such application a child entitled to a child's insurance benefit on the basis of the wages and self-employment income of such individual,

(C) in the case of a divorced wife, is not married, and

(D) is not entitled to old-age or disability insurance benefits, or is entitled to old-age or disability insurance benefits based on a primary insurance amount which is less than one-half of the primary insurance amount of such individual,

shall (subject to subsection (s)) be entitled to a wife's insurance benefit for each month, beginning with—

(i) in the case of a wife or divorced wife (as so defined) of an individual entitled to old-age benefits, if such wife or divorced wife has attained retirement age (as defined in section 216(l)), the first month in which she meets the criteria specified in subparagraphs (A), (B), (C), and (D), or

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[34] See Vol. II, P.L. 97-248, §278(d), with respect to deemed entitlement for hospital insurance benefits purposes.

See Vol. II, P.L. 97-377, §156(d), with respect to information furnished for determination of payments to surviving spouses of members of the Armed Forces.

See Vol. II, P.L. 98-21, §131(d)(2), with respect to the application requirement for individuals not entitled to benefits for December 1983.

[35] See Vol. II, P.L. 95-216, §334(g), where government service is involved.

(ii) in the case of a wife or divorced wife (as so defined) of—

(I) an individual entitled to old-age insurance benefits, if such wife or divorced wife has not attained retirement age (as defined in section 216(l)), or

(II) an individual entitled to disability insurance benefits,

the first month throughout which she is such a wife or divorced wife and meets the criteria specified in subparagraphs (B), (C), and (D) (if in such month she meets the criterion specified in subparagraph (A)),

whichever is earlier, and ending with the month preceding the month in which any of the following occurs—

(E) she dies,

(F) such individual dies,

(G) in the case of a wife, they are divorced and either (i) she has not attained age 62, or (ii) she has attained age 62 but has not been married to such individual for a period of 10 years immediately before the date the divorce became effective,

(H) in the case of a divorced wife, she marries a person other than such individual,

(I) in the case of a wife who has not attained age 62, no child of such individual is entitled to a child's insurance benefit,

(J) she becomes entitled to an old-age or disability insurance benefit based on a primary insurance amount which is equal to or exceeds one-half of the primary insurance amount of such individual, or

(K) such individual is not entitled to disability insurance benefits and is not entitled to old-age insurance benefits.

(2) Except as provided in subsection (q) and paragraph (4) of this subsection, such wife's insurance benefit for each month shall be equal to one-half of the primary insurance amount of her husband (or, in the case of a divorced wife, her former husband) for such month.

(3) In the case of any divorced wife who marries—

(A) an individual entitled to benefits under subsection (c), (f), (g), or (h) of this section, or

(B) an individual who has attained the age of 18 and is entitled to benefits under subsection (d),

such divorced wife's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) (but subject to subsection (s)), not be terminated by reason of such marriage.

(4)(A) The amount of a wife's insurance benefit for each month (as determined after application of the provisions of subsections (q) and (k)) shall be reduced (but not below zero) by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to the wife (or divorced wife) for such month which is based upon her earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2)) if, on the last day she was employed by such entity—

(i) such service did not constitute "employment" as defined in section 210, or[36]

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[36] See Vol. II, P.L. 100-647, §8014(b), with respect to clarification of applicability of government pension offset to certain Federal employees.

(ii) such service was being performed while in the service of the Federal Government, and constituted "employment" as so defined solely by reason of—

(I) clause (ii) or (iii) of subparagraph (G) of section 210(a)(5), where the lump-sum payment described in such clause (ii) or the cessation of coverage described in such clause (iii) (whichever is applicable) was received or occurred on or after January 1, 1988, or

(II) an election to become subject to the Federal Employees' Retirement System provided in chapter 84 of title 5, United States Code, or the Foreign Service Pension System provided in subchapter II of chapter 8 of title I of the Foreign Service Act of 1980 made pursuant to law after December 31, 1987,

unless subparagraph (B) applies.

The amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10.

(B) Subparagraph (A)(ii) shall not apply with respect to monthly periodic benefits based in whole or in part on service which constituted "employment" as defined in section 210 if such service was performed for at least 60 months in the aggregate during the period beginning January 1, 1988, and ending with the close of the first calendar month as of the end of which the wife (or divorced wife) is eligible for benefits under this subsection and has made a valid application for such benefits.

(C) For purposes of this paragraph, any periodic benefit which otherwise meets the requirements of subparagraph (A), but which is paid on other than a monthly basis, shall be allocated on a basis equivalent to a monthly benefit (as determined by the Secretary) and such equivalent monthly benefit shall constitute a monthly periodic benefit for purposes of subparagraph (A). For purposes of this subparagraph, the term "periodic benefit" includes a benefit payable in a lump sum if it is a commutation of, or a substitute for, periodic payments.

(5)(A) Notwithstanding the preceding provisions of this subsection, except as provided in subparagraph (B), the divorced wife of an individual who is not entitled to old-age or disability insurance benefits, but who has attained age 62 and is a fully insured individual (as defined in section 214), if such divorced wife—

(i) meets the requirements of subparagraphs (A) through (D) of paragraph (1), and

(ii) has been divorced from such insured individual for not less than 2 years,

shall be entitled to a wife's insurance benefit under this subsection for each month, in such amount, and beginning and ending with such months, as determined (under regulations of the Secretary) in the manner otherwise provided for wife's insurance benefits under this subsection, as if such insured individual had become entitled to old-age insurance benefits on the date on which the divorced wife first meets the criteria for entitlement set forth in clauses (i) and (ii).

(B) A wife's insurance benefit provided under this paragraph which has not otherwise terminated in accordance with subparagraph (E), (F), (H), or (J) of paragraph (1) shall terminate with the month preceding the first month in which the insured individual is no longer a fully insured individual.

Husband's Insurance Benefits[37]

(c)(1) The husband (as defined in section 216(f)) and every divorced husband (as defined in section 216(d)) of an individual entitled to old-age or disability insurance benefits, if such husband or such divorced husband—

(A) has filed application for husband's insurance benefits,

(B) has attained age 62 or (in the case of a husband) has in his care (individually or jointly with such individual) at the time of filing such application a child entitled to child's insurance benefits on the basis of the wages and self-employment income of such individual,

(C) in the case of a divorced husband, is not married, and

(D) is not entitled to old-age or disability insurance benefits, or is entitled to old-age or disability insurance benefits based on a primary insurance amount which is less than one-half of the primary insurance amount of such individual,

shall (subject to subsection (s)) be entitled to a husband's insurance benefit for each month, beginning with—

(i) in the case of a husband or divorced husband (as so defined) of an individual who is entitled to an old-age insurance benefit, if such husband or divorced husband has attained retirement age (as defined in section 216(l)), the first month in which he meets the criteria specified in subparagraphs (A), (B), (C), and (D), or

(ii) in the case of a husband or divorced husband (as so defined) of—

(I) an individual entitled to old-age insurance benefits, if such husband or divorced husband has not attained retirement age (as defined in section 216(l)), or

(II) an individual entitled to disability insurance benefits,

the first month throughout which he is such a husband or divorced husband and meets the criteria specified in subparagraphs (B), (C), and (D) (if in such month he meets the criterion specified in subparagraph (A)),

whichever is earlier, and ending with the month preceding the month in which any of the following occurs:

(E) he dies,

(F) such individual dies,

(G) in the case of a husband, they are divorced and either (i) he has not attained age 62, or (ii) he has attained age 62 but has not been married to such individual for a period of 10 years immediately before the divorce became effective,

(H) in the case of a divorced husband, he marries a person other than such individual,

(I) in the case of a husband who has not attained age 62, no child of such individual is entitled to a child's insurance benefit,

(J) he becomes entitled to an old-age or disability insurance benefit based on a primary insurance amount which is equal to or exceeds one-half of the primary insurance amount of such individual, or

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[37] See Vol. II, P.L. 95-216, §334(g), where government service is involved.

(K) such individual is not entitled to disability insurance benefits and is not entitled to old-age insurance benefits.

(2)(A) The amount of a husband's insurance benefit for each month (as determined after application of the provisions of subsections (q) and (k)) shall be reduced (but not below zero) by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to the husband (or divorced husband) for such month which is based upon his earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2)) if, on the last day he was employed by such entity—

(i) such service did not constitute "employment" as defined in section 210, or[38]

(ii) such service was being performed while in the service of the Federal Government, and constituted "employment" as so defined solely by reason of—

(I) clause (ii) or (iii) of subparagraph (G) of section 210(a)(5), where the lump-sum payment described in such clause (ii) or the cessation of coverage described in such clause (iii) (whichever is applicable) was received or occurred on or after January 1, 1988, or

(II) an election to become subject to the Federal Employees' Retirement System provided in chapter 84 of title 5, United States Code, or the Foreign Service Pension System provided in subchapter II of chapter 8 of title I of the Foreign Service Act of 1980 made pursuant to law after December 31, 1987,

unless subparagraph (B) applies.

The amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10.

(B) Subparagraph (A)(ii) shall not apply with respect to monthly periodic benefits based in whole or in part on service which constituted "employment" as defined in section 210 if such service was performed for at least 60 months in the aggregate during the period beginning January 1, 1988, and ending with the close of the first calendar month as of the end of which the husband (or divorced husband) is eligible for benefits under this subsection and has made a valid application for such benefits.

(C) For purposes of this paragraph, any periodic benefit which otherwise meets the requirements of subparagraph (A), but which is paid on other than a monthly basis, shall be allocated on a basis equivalent to a monthly benefit (as determined by the Secretary) and such equivalent monthly benefit shall constitute a monthly periodic benefit for purposes of subparagraph (A). For purposes of this subparagraph, the term "periodic benefit" includes a benefit payable in a lump sum if it is a commutation of, or a substitute for, periodic payments.

(3) Except as provided in subsection (q) and paragraph (2) of this subsection, such husband's insurance benefit for each month shall be equal to one-half of the primary insurance amount of his wife (or, in the case of a divorced husband, his former wife) for such month.

(4) In the case of any divorced husband who marries—

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[38] See Vol. II, P.L. 100-647, §8014(b), with respect to clarification of applicability of government pension offset to certain Federal employees.

(A) an individual entitled to benefits under subsection (b), (e), (g), or (h) of this section, or

(B) an individual who has attained the age of 18 and is entitled to benefits under subsection (d), by reason of paragraph (1)(B)(ii) thereof,

such divorced husband's entitlement to benefits under this subsection, notwithstanding the provisions of paragraph (1) (but subject to subsection (s)), shall not be terminated by reason of such marriage.

(5)(A) Notwithstanding the preceding provisions of this subsection, except as provided in subparagraph (B), the divorced husband of an individual who is not entitled to old-age or disability insurance benefits, but who has attained age 62 and is a fully insured individual (as defined in section 214), if such divorced husband—

(i) meets the requirements of subparagraphs (A) through (D) of paragraph (1), and

(ii) has been divorced from such insured individual for not less than 2 years,

shall be entitled to a husband's insurance benefit under this subsection for each month, in such amount, and beginning and ending with such months, as determined (under regulations of the Secretary) in the manner otherwise provided for husband's insurance benefits under this subsection, as if such insured individual had become entitled to old-age insurance benefits on the date on which the divorced husband first meets the criteria for entitlement set forth in clauses (i) and (ii).

(B) A husband's insurance benefit provided under this paragraph which has not otherwise terminated in accordance with subparagraph (E), (F), (H), or (J) of paragraph (1) shall terminate with the month preceding the first month in which the insured individual is no longer a fully insured individual.

Child's Insurance Benefits

(d)(1) Every child (as defined in section 216(e)) of an individual entitled to old-age or disability insurance benefits, or of an individual who dies a fully or currently insured individual, if such child—

(A) has filed application for child's insurance benefits,

(B) at the time such application was filed was unmarried and (i) either had not attained the age of 18 or was a full-time elementary or secondary school student and had not attained the age of 19, or (ii) is under a disability (as defined in section 223(d)) which began before he attained the age of 22, and

(C) was dependent upon such individual—

(i) if such individual is living, at the time such application was filed,

(ii) if such individual has died, at the time of such death, or

(iii) if such individual had a period of disability which continued until he became entitled to old-age or disability insurance benefits, or (if he has died) until the month of his death, at the beginning of such period of disability or at the time he became entitled to such benefits,

shall be entitled to a child's insurance benefit for each month, beginning with—

(i) in the case of a child (as so defined) of such an individual who has died, the first month in which such child meets the criteria specified in subparagraphs (A), (B), and (C), or

(ii) in the case of a child (as so defined) of an individual entitled to an old-age insurance benefit or to a disability insurance benefit, the first month throughout which such child is a child (as so defined) and meets the criteria specified in subparagraphs (B) and (C) (if in such month he meets the criterion specified in subparagraph (A)),

whichever is earlier, and ending with the month preceding whichever of the following first occurs—

(D) the month in which such child dies, or marries,

(E) the month in which such child attains the age of 18, but only if he (i) is not under a disability (as so defined) at the time he attains such age, and (ii) is not a full-time elementary or secondary school student during any part of such month,

(F) if such child was not under a disability (as so defined) at the time he attained the age of 18, the earlier of—

(i) the first month during no part of which he is a full-time elementary or secondary school student, or

(ii) the month in which he attains the age of 19,

but only if he was not under a disability (as so defined) in such earlier month; or

(G) if such child was under a disability (as so defined) at the time he attained the age of 18 or if he was not under a disability (as so defined) at such time but was under a disability (as so defined) at or prior to the time he attained (or would attain) the age of 22—

(i) the termination month, subject to section 223(e) (and for purposes of this subparagraph, the termination month for any individual shall be the third month following the month in which his disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 222(c)(4)(A), the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 36 months following such period of trial work in which he engages or is determined able to engage in substantial gainful activity),

or (if later) the earlier of—

(ii) the first month during no part of which he is a full-time elementary or secondary school student, or

(iii) the month in which he attains the age of 19,

but only if he was not under a disability (as so defined) in such earlier month.

Entitlement of any child to benefits under this subsection on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits shall also end with the month before the first month for which such individual is not entitled to such benefits unless such individual is, for such later month, entitled to old-age insurance benefits or unless he dies in such month. No payment under this paragraph may be made to a child who would not meet the definition of disability in section 223(d) except for paragraph (1)(B) thereof for any month in which he engages in substantial gainful activity.

(2) Such child's insurance benefit for each month shall, if the individual on the basis of whose wages and self-employment income the child is entitled to such benefit has not died prior to the end of such month, be equal to one-half of the primary insurance amount of such individual for such month. Such child's insurance benefit for each month shall, if such individual has died in or prior to such month, be equal to three-fourths of the primary insurance amount of such individual.

(3) A child shall be deemed dependent upon his father or adopting father or his mother or adopting mother at the time specified in paragraph (1)(C) unless, at such time, such individual was not living with or contributing to the support of such child and—

(A) such child is neither the legitimate nor adopted child of such individual, or

(B) such child has been adopted by some other individual.

For purposes of this paragraph, a child deemed to be a child of a fully or currently insured individual pursuant to section 216(h)(2)(B) or section 216(h)(3) shall be deemed to be the legitimate child of such individual.

(4) A child shall be deemed dependent upon his stepfather or stepmother at the time specified in paragraph (1)(C) if, at such time, the child was living with or was receiving at least one-half of his support from such stepfather or stepmother.

(5) In the case of a child who has attained the age of eighteen and who marries—

(A) an individual entitled to benefits under subsection (a), (b), (c), (e), (f), (g), or (h) of this section or under section 223(a), or

(B) another individual who has attained the age of eighteen and is entitled to benefits under this subsection,

such child's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) but subject to subsection (s), not be terminated by reason of such marriage.

(6) A child whose entitlement to child's insurance benefits on the basis of the wages and self-employment income of an insured individual terminated with the month preceding the month in which such child attained the age of 18, or with a subsequent month, may again become entitled to such benefits (provided no event specified in paragraph (1)(D) has occurred) beginning with the first month thereafter in which he—

(A)(i) is a full-time elementary or secondary school student and has not attained the age of 19, or (ii) is under a disability (as defined in section 223(d)) and has not attained the age of 22, or

(B) is under a disability (as so defined) which began before the close of the 84th month following the month in which his most recent entitlement to child's insurance benefits terminated because he ceased to be under such disability, but only if he has filed application for such reentitlement. Such reentitlement shall end with the month preceding whichever of the following first occurs:

(C) the first month in which an event specified in paragraph (1)(D) occurs;

(D) the earlier of (i) the first month during no part of which he is a full-time elementary or secondary school student or (ii) the month in which he attains the age of 19, but only if he is not under a disability (as so defined) in such earlier month; or

(E) if he was under a disability (as so defined), the termination month (as defined in paragraph (1)(G)(i)), subject to section 223(e), or (if later) the earlier of—

(i) the first month during no part of which he is a full-time elementary or secondary school student, or

(ii) the month in which he attains the age of 19.

(7) For the purposes of this subsection—

(A) A "full-time elementary or secondary school student" is an individual who is in full-time attendance as a student at an elementary or secondary school, as determined by the Secretary (in accordance with regulations prescribed by him) in the light of the standards and practices of the schools involved, except that no individual shall be considered a "full-time elementary or secondary school student" if he is paid by his employer while attending an elementary or secondary school at the request, or pursuant to a requirement, of his employer. An individual shall not be considered a "full-time elementary or secondary school student" for the purpose of this section while that individual is confined in a jail, prison, or other penal institution or correctional facility, pursuant to his conviction of an offense (committed after the effective date of this sentence[39]) which constituted a felony under applicable law. An individual who is determined to be a full-time elementary or secondary school student shall be deemed to be such a student throughout the month with respect to which such determination is made.

(B) Except to the extent provided in such regulations, an individual shall be deemed to be a full-time elementary or secondary school student during any period of nonattendance at an elementary or secondary school at which he has been in full-time attendance if (i) such period is 4 calendar months or less, and (ii) he shows to the satisfaction of the Secretary that he intends to continue to be in full-time attendance at an elementary or secondary school immediately following such period. An individual who does not meet the requirement of clause (ii) with respect to such period of nonattendance shall be deemed to have met such requirement (as of the beginning of such period) if he is in full-time attendance at an elementary or secondary school immediately following such period.

(C)(i) An "elementary or secondary school" is a school which provides elementary or secondary education, respectively, as determined under the law of the State or other jurisdiction in which it is located.

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[39] October 1, 1980 [P.L. 96-473, §5(b); 94 Stat. 2265].

(ii) For the purpose of determining whether a child is a "full-time elementary or secondary school student" or "intends to continue to be in full-time attendance at an elementary or secondary school", within the meaning of this subsection, there shall be disregarded any education provided, or to be provided, beyond grade 12.

(D) A child who attains age 19 at a time when he is a full-time elementary or secondary school student (as defined in subparagraph (A) of this paragraph and without application of subparagraph (B) of such paragraph) but has not (at such time) completed the requirements for, or received, a diploma or equivalent certificate from a secondary school (as defined in subparagraph (C)(i)) shall be deemed (for purposes of determining whether his entitlement to benefits under this subsection has terminated under paragraph (1)(F) and for purposes of determining his initial entitlement to such benefits under clause (i) of paragraph (1)(B)) not to have attained such age until the first day of the first month following the end of the quarter or semester in which he is enrolled at such time (or, if the elementary or secondary school (as defined in this paragraph) in which he is enrolled is not operated on a quarter or semester system, until the first day of the first month following the completion of the course in which he is so enrolled or until the first day of the third month beginning after such time, whichever first occurs).

(8) In the case of—

(A) an individual entitled to old-age insurance benefits (other than an individual referred to in subparagraph (B)), or

(B) an individual entitled to disability insurance benefits, or an individual entitled to old-age insurance benefits who was entitled to disability insurance benefits for the month preceding the first month for which he was entitled to old-age insurance benefits,

a child of such individual adopted after such individual became entitled to such old-age or disability insurance benefits shall be deemed not to meet the requirements of clause (i) or (iii) of paragraph (1)(C) unless such child—

(C) is the natural child or stepchild of such individual (including such a child who was legally adopted by such individual), or

(D)(i) was legally adopted by such individual in an adoption decreed by a court of competent jurisdiction within the United States, and[40]

(ii) in the case of a child who attained the age of 18 prior to the commencement of proceedings for adoption, the child was living with or receiving at least one-half of the child's support from such individual for the year immediately preceding the month in which the adoption is decreed[41] [42]

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[40] P.L. 101-239, §10301(a)(1), added "and".

[41] P.L. 101-239, §10301(a)(2), struck out clauses (ii) and (iii) and inserted a new clause (ii), applicable to benefits payable for months after December 1989, but only on the basis of applications filed on or after January 1, 1990. [For clauses (ii) and (iii), as they formerly read, see Vol. III, P.L. 101-239.]

As in original; alinement not consistent with that of clause (i) and end punctuation missing.

[42] P.L. 101-239, §10301(b), struck out a sentence reading as follows: "In the case of a child who was born in the one-year period during which such child must have been living with and receiving at least one-half of his support from such individual, such child shall be deemed to meet such requirements for such period if, as of the close of such period, such child has lived with such individual in the United States and received at least one-half of his support from such individual

(9)(A) A child who is a child of an individual under clause (3) of the first sentence of section 216(e) and is not a child of such individual under clause (1) or (2) of such first sentence shall be deemed not to be dependent on such individual at the time specified in subparagraph (1)(C) of this subsection unless (i) such child was living with such individual in the United States and receiving at least one-half of his support from such individual (I) for the year immediately before the month in which such individual became entitled to old-age insurance benefits or disability insurance benefits or died, or (II) if such individual had a period of disability which continued until he had become entitled to old-age insurance benefits, or disability insurance benefits, or died, for the year immediately before the month in which such period of disability began, and (ii) the period during which such child was living with such individual began before the child attained age 18.

(B) In the case of a child who was born in the one-year period during which such child must have been living with and receiving at least one-half of his support from such individual, such child shall be deemed to meet such requirements for such period if, as of the close of such period, such child has lived with such individual in the United States and received at least one-half of his support from such individual for substantially all of the period which begins on the date of such child's birth.

Widow's Insurance Benefits[43]

(e)(1) The widow (as defined in section 216(c)) and every surviving divorced wife (as defined in section 216(d)) of an individual who died a fully insured individual, if such widow or such surviving divorced wife—

(A) is not married,

(B)(i) has attained age 60, or (ii) has attained age 50 but has not attained age 60 and is under a disability (as defined in section 223(d)) which began before the end of the period specified in paragraph (4),

(C)(i) has filed application for widow's insurance benefits,[44]

(ii) was entitled to wife's insurance benefits, on the basis of the wages and self-employment income of such individual, for the month preceding the month in which such individual died, and—

(I) has attained retirement age (as defined in section 216(l)),

(II) is not entitled to benefits under subsection (a) or section 223, or

(III) has in effect a certificate (described in paragraph (8)) filed by her with the Secretary, in accordance with regulations prescribed by the Secretary, in which she elects to receive widow's insurance benefits (subject to reduction as provided in subsection (q)), or

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for substantially all of the period which begins on the date of birth of such child.", applicable to benefits payable for months after December 1989, but on the basis of applications filed on or after January 1, 1990.

[43] See Vol. II, P.L. 95-216, §334(g), where government service is involved.

[44] See Vol. II, P.L. 88-525, §11(i) and (j), with respect to accepting applications for food stamps at Social Security Administration offices.

(iii) was entitled, on the basis of such wages and self-employment income, to mother's insurance benefits for the month preceding the month in which she attained retirement age (as defined in section 216(l)), and

(D) is not entitled to old-age insurance benefits or is entitled to old-age insurance benefits each of which is less than the primary insurance amount (as determined after application of subparagraphs (B) and (C) of paragraph (2)) of such deceased individual,

shall be entitled to a widow's insurance benefit for each month, beginning with—

(E) if she satisfies subparagraph (B) by reason of clause (i) thereof, the first month in which she becomes so entitled to such insurance benefits, or

(F) if she satisfies subparagraph (B) by reason of clause (ii) thereof—

(i) the first month after her waiting period (as defined in paragraph (5)) in which she becomes so entitled to such insurance benefits, or

(ii) the first month during all of which she is under a disability and in which she becomes so entitled to such insurance benefits, but only if she was previously entitled to insurance benefits under this subsection on the basis of being under a disability and such first month occurs (I) in the period specified in paragraph (4) and (II) after the month in which a previous entitlement to such benefits on such basis terminated,

and ending with the month preceding the first month in which any of the following occurs: she remarries, dies, becomes entitled to an old-age insurance benefit equal to or exceeding the primary insurance amount (as determined after application of subparagraphs (B) and (C) of paragraph (2)) of such deceased individual, or, if she became entitled to such benefits before she attained age 60, subject to section 223(e), the termination month (unless she attains retirement age (as defined in section 216(l)) on or before the last day of such termination month). For purposes of the preceding sentence, the termination month for any individual shall be the third month following the month in which her disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 222(c)(4)(A), the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 36 months following such period of trial work in which she engages or is determined able to engage in substantial gainful activity.

(2)(A) Except as provided in subsection (q), paragraph (7) of this subsection, and subparagraph (D) of this paragraph, such widow's insurance benefit for each month shall be equal to the primary insurance amount (as determined for purposes of this subsection after application of subparagraphs (B) and (C)) of such deceased individual.

(B)(i) For purposes of this subsection, in any case in which such deceased individual dies before attaining age 62 and section 215(a)(1) (as in effect after December 1978) is applicable in determining such individual's primary insurance amount—

(I) such primary insurance amount shall be determined under the formula set forth in section 215(a)(1)(B)(i) and (ii) which is applicable to individuals who initially become eligible for old-age insurance benefits in the second year after the year specified in clause (ii),

(II) the year specified in clause (ii) shall be substituted for the second calendar year specified in section 215(b)(3)(A)(ii)(I), and

(III) such primary insurance amount shall be increased under section 215(i) as if it were the primary insurance amount referred to in section 215(i)(2)(A)(ii)(II), except that it shall be increased only for years beginning after the first year after the year specified in clause (ii).

(ii) The year specified in this clause is the earlier of—

(I) the year in which the deceased individual attained age 60, or would have attained age 60 had he lived to that age, or

(II) the second year preceding the year in which the widow or surviving divorced wife first meets the requirements of paragraph (1)(B) or the second year preceding the year in which the deceased individual died, whichever is later.

(iii) This subparagraph shall apply with respect to any benefit under this subsection only to the extent its application does not result in a primary insurance amount for purposes of this subsection which is less than the primary insurance amount otherwise determined for such deceased individual under section 215.

(C) If such deceased individual was (or upon application would have been) entitled to an old-age insurance benefit which was increased (or subject to being increased) on account of delayed retirement under the provisions of subsection (w), then, for purposes of this subsection, such individual's primary insurance amount, if less than the old-age insurance benefit (increased, where applicable, under section 215(f)(5), 215(f)(6), or 215(f)(9)(B) and under section 215(i) as if such individual were still alive in the case of an individual who has died) which he was receiving (or would upon application have received) for the month prior to the month in which he died, shall be deemed to be equal to such old-age insurance benefit, and (notwithstanding the provisions of paragraph (3) of such subsection (w)) the number of increment months shall include any month in the months of the calendar year in which he died, prior to the month in which he died, which satisfy the conditions in paragraph (2) of such subsection (w).

(D) If the deceased individual (on the basis of whose wages and self-employment income a widow or surviving divorced wife is entitled to widow's insurance benefits under this subsection) was, at any time, entitled to an old-age insurance benefit which was reduced by reason of the application of subsection (q), the widow's insurance benefit of such widow or surviving divorced wife for any month shall, if the amount of the widow's insurance benefit of such widow or surviving divorced wife (as determined under subparagraph (A) and after application of subsection (q)) is greater than—

(i) the amount of the old-age insurance benefit to which such deceased individual would have been entitled (after application of subsection (q)) for such month if such individual were still living and section 215(f)(5), 215(f)(6), or 215(f)(9)(B) were applied, where applicable, and

(ii) 82 1/2 percent of the primary insurance amount (as determined without regard to subparagraph (C)) of such deceased individual,

be reduced to the amount referred to in clause (i), or (if greater) the amount referred to in clause (ii).

(3) For purposes of paragraph (1), if—

(A) a widow or surviving divorced wife marries after attaining age 60 (or after attaining age 50 if she was entitled before such marriage occurred to benefits based on disability under this subsection), or

(B) a disabled widow or disabled surviving divorced wife described in paragraph (1)(B)(ii) marries after attaining age 50,

such marriage shall be deemed not to have occurred.

(4) The period referred to in paragraph (1)(B)(ii), in the case of any widow or surviving divorced wife, is the period beginning with whichever of the following is the latest:

(A) the month in which occurred the death of the fully insured individual referred to in paragraph (1) on whose wages and self-employment income her benefits are or would be based, or

(B) the last month for which she was entitled to mother's insurance benefits on the basis of the wages and self-employment income of such individual, or

(C) the month in which a previous entitlement to widow's insurance benefits on the basis of such wages and self-employment income terminated because her disability had ceased,

and ending with the month before the month in which she attains age 60, or, if earlier, with the close of the eighty-fourth month following the month with which such period began.

(5)(A)[45] The waiting period referred to in paragraph (1)(F), in the case of any widow or surviving divorced wife, is the earliest period of five consecutive calendar months—

(i)[46] throughout which she has been under a disability, and

(ii)[47] which begins not earlier than with whichever of the following is the later: (I)[48] the first day of the seventeenth month before the month in which her application is filed, or (II)[49] the first day of the fifth month before the month in which the period specified in paragraph (4) begins.

(B) For purposes of paragraph (1)(F)(i), each month in the period commencing with the first month for which such widow or surviving divorced wife is first eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93-66) which are paid by the Secretary under an agreement referred to in section 1616(a) (or in section 212(b) of Public Law 93-66), shall be included as one of the months of such waiting period for which the requirements of subparagraph (A) have been met.[50]

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[45] P.L. 101-508, §5103(c)(2)(A)(iii), redesignated paragraph (5) as subparagraph (5)(A).
[46] P.L. 101-508, §5103(c)(2)(A)(ii), redesignated subparagraph (A) as clause (i).
[47] P.L. 101-508, §5103(c)(2)(A)(ii), redesignated subparagraph (B) as clause (ii).
[48] P.L. 101-508, §5103(c)(2)(A)(i), redesignated clause (i) as subclause (I).
[49] P.L. 101-508, §5103(c)(2)(A)(i), redesignated clause (ii) as subclause (II).

(6) In the case of an individual entitled to monthly insurance benefits payable under this section for any month prior to January 1973 whose benefits were not redetermined under section 102(g) of the Social Security Amendments of 1972[51], such benefits shall not be redetermined pursuant to such section, but shall be increased pursuant to any general benefit increase (as defined in section 215(i)(3)) or any increase in benefits made under or pursuant to section 215(i), including for this purpose the increase provided effective for March 1974, as though such redetermination had been made.

(7)(A) The amount of a widow's insurance benefit for each month (as determined after application of the provisions of subsections (q) and (k), paragraph (2)(D), and paragraph (3)) shall be reduced (but not below zero) by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to the widow (or surviving divorced wife) for such month which is based upon her earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2)) if, on the last day she was employed by such entity—

(i) such service did not constitute "employment" as defined in section 210, or[52]

(ii) such service was being performed while in the service of the Federal Government, and constituted "employment" as so defined solely by reason of—

(I) clause (ii) or (iii) of subparagraph (G) of section 210(a)(5), where the lump-sum payment described in such clause (ii) or the cessation of coverage described in such clause (iii) (whichever is applicable) was received or occurred on or after January 1, 1988, or

(II) an election to become subject to the Federal Employees' Retirement System provided in chapter 84 of title 5, United States Code, or the Foreign Service Pension System provided in subchapter II of chapter 8 of title I of the Foreign Service Act of 1980 made pursuant to law after December 31, 1987,

unless subparagraph (B) applies.

The amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10.

(B) Subparagraph (A)(ii) shall not apply with respect to monthly periodic benefits based in whole or in part on service which constituted "employment" as defined in section 210 if such service was performed for at least 60 months in the aggregate during the period beginning January 1, 1988, and ending with the close of the first calendar month as of the end of which the widow (or surviving divorced wife) is eligible for benefits under this subsection and has made a valid application for such benefits.

(C) For purposes of this paragraph, any periodic benefit which otherwise meets the requirements of subparagraph (A), but which is paid on other than a monthly basis, shall be allocated on a basis equivalent to a monthly benefit (as determined by the Secretary) and such equivalent monthly benefit shall constitute a monthly periodic benefit for purposes of subparagraph (A). For purposes of this subparagraph, the term "periodic benefit" includes a benefit payable in a lump sum if it is a commutation of, or a substitute for, periodic payments.

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[50] P.L. 101-508, §5103(c)(2)(A)(iv), added subparagraph (B). For the effective date, see Vol. II, P.L. 101-508, §5103(e).

[51] P.L. 92-603.

[52] See Vol. II, P.L. 100-647, §8014(b), with respect to clarification of applicability of government pension offset to certain Federal employees.

(8) Any certificate filed pursuant to paragraph (1)(C)(ii)(III) shall be effective for purposes of this subsection—

(A) for the month in which it is filed and for any month thereafter, and

(B) for months, in the period designated by the individual filing such certificate, of one or more consecutive months (not exceeding 12) immediately preceding the month in which such certificate is filed;

except that such certificate shall not be effective for any month before the month in which she attains age 62.

(9) An individual shall be deemed to be under a disability for purposes of paragraph (1)(B)(ii) if such individual is eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93-66) which are paid by the Secretary under an agreement referred to in section 1616(a) (or in section 212(b) of Public Law 93-66), for the month for which all requirements of paragraph (1) for entitlement to benefits under this subsection (other than being under a disability) are met.[53]

Widower's Insurance Benefits[54]

(f)(1) The widower (as defined in section 216(g)) and every surviving divorced husband (as defined in section 216(d)) of an individual who died a fully insured individual, if such widower or such surviving divorced husband—

(A) is not married,

(B)(i) has attained age 60, or (ii) has attained age 50 but has not attained age 60 and is under a disability (as defined in section 223(d)) which began before the end of the period specified in paragraph (5),

(C)(i) has filed application for widower's insurance benefits,

(ii) was entitled to husband's insurance benefits, on the basis of the wages and self-employment income of such individual, for the month preceding the month in which such individual died, and—

(I) has attained retirement age (as defined in section 216(l)),

(II) is not entitled to benefits under subsection (a) or section 223, or

(III) has in effect a certificate (described in paragraph (8)) filed by him with the Secretary, in accordance with regulations prescribed by the Secretary, in which he elects to receive widower's insurance benefits (subject to reduction as provided in subsection (q)), or

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[53] P.L. 101-508, §5103(d)(1), added paragraph (9). For the effective date, see Vol. II, P.L. 101-508, §5103(e).

[54] See Vol. II, P.L. 88-525, §11(i) and (j), with respect to accepting applications for food stamps at Social Security Administration offices.

See Vol. II, P.L. 95-216, §334(g), where government service is involved.

(iii) was entitled, on the basis of such wages and self-employment income, to father's insurance benefits for the month preceding the month in which he attained retirement age (as defined in section 216(l)), and

(D) is not entitled to old-age insurance benefits, or is entitled to old-age insurance benefits each of which is less than the primary insurance amount (as determined after application of subparagraphs (B) and (C) of paragraph (3)) of such deceased individual,

shall be entitled to a widower's insurance benefit for each month, beginning with—

(E) if he satisfies subparagraph (B) by reason of clause (i) thereof, the first month in which he becomes so entitled to such insurance benefits, or

(F) if he satisfies subparagraph (B) by reason of clause (ii) thereof—

(i) the first month after his waiting period (as defined in paragraph (6)) in which he becomes so entitled to such insurance benefits, or

(ii) the first month during all of which he is under a disability and in which he becomes so entitled to such insurance benefits, but only if he was previously entitled to insurance benefits under this subsection on the basis of being under a disability and such first month occurs (I) in the period specified in paragraph (5) and (II) after the month in which a previous entitlement to such benefits on such basis terminated,

and ending with the month preceding the first month in which any of the following occurs: he remarries, dies, or becomes entitled to an old-age insurance benefit equal to or exceeding the primary insurance amount (as determined after application of subparagraphs (B) and (C) of paragraph (3)) of such deceased individual, or, if he became entitled to such benefits before he attained age 60, subject to section 223(e), the termination month (unless he attains retirement age (as defined in section 216(l)) on or before the last day of such termination month). For purposes of the preceding sentence, the termination month for any individual shall be the third month following the month in which his disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 222(c)(4)(A), the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 36 months following such period of trial work in which he engages or is determined able to engage in substantial gainful activity.

(2)(A) The amount of a widower's insurance benefit for each month (as determined after application of the provisions of subsections (q) and (k), paragraph (3)(D), and paragraph (4)) shall be reduced (but not below zero) by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to the widower (or surviving divorced husband) for such month which is based upon his earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2)) if, on the last day he was employed by such entity—

(i) such service did not constitute "employment" as defined in section 210, or[55]

(ii) such service was being performed while in the service of the Federal Government, and constituted "employment" as so defined solely by reason of—

(I) clause (ii) or (iii) of subparagraph (G) of section 210(a)(5), where the lump-sum payment described in such clause (ii) or the cessation of coverage described in such clause (iii) (whichever is applicable) was received or occurred on or after January 1, 1988, or

(II) an election to become subject to the Federal Employees' Retirement System provided in chapter 84 of title 5, United States Code, or the Foreign Service Pension System provided in subchapter II of chapter 8 of title I of the Foreign Service Act of 1980 made pursuant to law after December 31, 1987,

unless subparagraph (B) applies.

The amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10.

(B) Subparagraph (A)(ii) shall not apply with respect to monthly periodic benefits based in whole or in part on service which constituted "employment" as defined in section 210 if such service was performed for at least 60 months in the aggregate during the period beginning January 1, 1988, and ending with the close of the first calendar month as of the end of which the widower (or surviving divorced husband) is eligible for benefits under this subsection and has made a valid application for such benefits.

(C) For purposes of this paragraph, any periodic benefit which otherwise meets the requirements of subparagraph (A), but which is paid on other than a monthly basis, shall be allocated on a basis equivalent to a monthly benefit (as determined by the Secretary) and such equivalent monthly benefit shall constitute a monthly periodic benefit for purposes of subparagraph (A). For purposes of this subparagraph, the term "periodic benefit" includes a benefit payable in a lump sum if it is a commutation of, or a substitute for, periodic payments.

(3)(A) Except as provided in subsection (q), paragraph (2) of this subsection, and subparagraph (D) of this paragraph, such widower's insurance benefit for each month shall be equal to the primary insurance amount (as determined for purposes of this subsection after application of subparagraphs (B) and (C)) of such deceased individual.

(B)(i) For purposes of this subsection, in any case in which such deceased individual dies before attaining age 62 and section 215(a)(1) (as in effect after December 1978) is applicable in determining such individual's primary insurance amount—

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[55] See Vol. II, P.L. 100-647, §8014(b), with respect to clarification of applicability of government pension offset to certain Federal employees.

(I) such primary insurance amount shall be determined under the formula set forth in section 215(a)(1)(B)(i) and (ii) which is applicable to individuals who initially become eligible for old-age insurance benefits in the second year after the year specified in clause (ii),

(II) the year specified in clause (ii) shall be substituted for the second calendar year specified in section 215(b)(3)(A)(ii)(I), and

(III) such primary insurance amount shall be increased under section 215(i) as if it were the primary insurance amount referred to in section 215(i)(2)(A)(ii)(II), except that it shall be increased only for years beginning after the first year after the year specified in clause (ii).

(ii) The year specified in this clause is the earlier of—

(I) the year in which the deceased individual attained age 60, or would have attained age 60 had she lived to that age, or

(II) the second year preceding the year in which the widower or surviving divorced husband first meets the requirements of paragraph (1)(B) or the second year preceding the year in which the deceased individual died, whichever is later.

(iii) This subparagraph shall apply with respect to any benefit under this subsection only to the extent its application does not result in a primary insurance amount for purposes of this subsection which is less than the primary insurance amount otherwise determined for such deceased individual under section 215.

(C) If such deceased individual was (or upon application would have been) entitled to an old-age insurance benefit which was increased (or subject to being increased) on account of delayed retirement under the provisions of subsection (w), then, for purposes of this subsection, such individual's primary insurance amount, if less than the old-age insurance benefit (increased, where applicable, under section 215(f)(5), 215(f)(6), or 215(f)(9)(B) and under section 215(i) as if such individual were still alive in the case of an individual who has died) which she was receiving (or would upon application have received) for the month prior to the month in which she died, shall be deemed to be equal to such old-age insurance benefit, and (notwithstanding the provisions of paragraph (3) of such subsection (w)) the number of increment months shall include any month in the months of the calendar year in which she died, prior to the month in which she died, which satisfy the conditions in paragraph (2) of such subsection (w).

(D) If the deceased individual (on the basis of whose wages and self-employment income a widower or surviving divorced husband is entitled to widower's insurance benefits under this subsection) was, at any time, entitled to an old-age insurance benefit which was reduced by reason of the application of subsection (q), the widower's insurance benefit of such widower or surviving divorced husband for any month shall, if the amount of the widower's insurance benefit of such widower or surviving divorced husband (as determined under subparagraph (A) and after application of subsection (q)) is greater than—

(i) the amount of the old-age insurance benefit to which such deceased individual would have been entitled (after application of subsection (q)) for such month if such individual were still living and section 215(f)(5), 215(f)(6), or 215(f)(9)(B) were applied, where applicable, and

(ii) 82 1/2 percent of the primary insurance amount (as determined without regard to subparagraph (C)) of such deceased individual;

be reduced to the amount referred to in clause (i), or (if greater) the amount referred to in clause (ii).

(4) For purposes of paragraph (1), if—

(A) a widower or surviving divorced husband marries after attaining age 60 (or after attaining age 50 if he was entitled before such marriage occurred to benefits based on disability under this subsection), or

(B) a disabled widower or surviving divorced husband described in paragraph (1)(B)(ii) marries after attaining age 50,

such marriage shall be deemed not to have occurred.

(5) The period referred to in paragraph (1)(B)(ii), in the case of any widower or surviving divorced husband, is the period beginning with whichever of the following is the latest:

(A) the month in which occurred the death of the fully insured individual referred to in paragraph (1) on whose wages and self-employment income his benefits are or would be based,

(B) the last month for which he was entitled to father's insurance benefits on the basis of the wages and self-employment income of such individual, or

(C) the month in which a previous entitlement to widower's insurance benefits on the basis of such wages and self-employment income terminated because his disability had ceased,

and ending with the month before the month in which he attains age 60, or, if earlier, with the close of the eighty-fourth month following the month with which such period began.

(6)(A)[56] The waiting period referred to in paragraph (1)(F), in the case of any widower or surviving divorced husband, is the earliest period of five consecutive calendar months—

(i)[57] throughout which he has been under a disability, and

(ii)[58] which begins not earlier than with whichever of the following is the later: (I)[59] the first day of the seventeenth month before the month in which his application is filed, or (II)[60] the first day of the fifth month before the month in which the period specified in paragraph (5) begins.

(B) For purposes of paragraph (1)(F)(i), each month in the period commencing with the first month for which such widower or surviving divorced husband is first eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93-66) which are paid by the Secretary under an agreement referred to in section 1616(a) (or in section 212(b) of Public Law 93-66), shall be included as one of the months of such waiting period for which the requirements of subparagraph (A) have been met.[61]

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[56] P.L. 101-508, §5103(c)(2)(B)(iii), redesignated paragraph (6) as subparagraph (A).

[57] P.L. 101-508, §5103(c)(2)(B)(ii), redesignated subparagraph (A) as clause (i).

[58] P.L. 101-508, §5103(c)(2)(B)(ii), redesignated subparagraph (B) as clause (ii).

[59] P.L. 101-508, §5103(c)(2)(B)(i), redesignated clause (i) as subclause (I).

[60] P.L. 101-508, §5103(c)(2)(B)(i), redesignated clause (ii) as subclause (II).

[61] P.L. 101-508, §5103(c)(2)(B)(iv), added subparagraph (B), applicable to monthly insurance benefits for months after December 1990 for which applications are filed on or after January 1, 1991, or are pending on such date.

(7) In the case of an individual entitled to monthly insurance benefits payable under this section for any month prior to January 1973 whose benefits were not redetermined under section 102(g) of the Social Security Amendments of 1972[62], such benefits shall not be redetermined pursuant to such section, but shall be increased pursuant to any general benefit increase (as defined in section 215(i)(3)) or any increase in benefits made under or pursuant to section 215(i), including for this purpose the increase provided effective for March 1974, as though such redetermination had been made.

(8) Any certificate filed pursuant to paragraph (1)(C)(ii)(III) shall be effective for purposes of this subsection—

(A) for the month in which it is filed and for any month thereafter, and

(B) for months, in the period designated by the individual filing such certificate, of one or more consecutive months (not exceeding 12) immediately preceding the month in which such certificate is filed;

except that such certificate shall not be effective for any month before the month in which he attains age 62.

(9) An individual shall be deemed to be under a disability for purposes of paragraph (1)(B)(ii) if such individual is eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93-66) which are paid by the Secretary under an agreement referred to in such section 1616(a) (or in section 212(b) of Public Law 93-66), for the month for which all requirements of paragraph (1) for entitlement to benefits under this subsection (other than being under a disability) are met.[63]

Mother's and Father's Insurance Benefits[64]

(g)(1) The surviving spouse and every surviving divorced parent (as defined in section 216(d)) of an individual who died a fully or currently insured individual, if such surviving spouse or surviving divorced parent—

(A) is not married,

(B) is not entitled to a surviving spouse's insurance benefit,

(C) is not entitled to old-age insurance benefits, or is entitled to old-age insurance benefits each of which is less than three-fourths of the primary insurance amount of such individual,

(D) has filed application for mother's or father's insurance benefits, or was entitled to a spouse's insurance benefit on the basis of the wages and self-employment income of such individual for the month preceding the month in which such individual died,

(E) at the time of filing such application has in his or her care a child of such individual entitled to a child's insurance benefit, and

(F) in the case of a surviving divorced parent—

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[62] P.L. 92-603.

[63] P.L. 101-508, §5103(d)(2), added paragraph (9), applicable to monthly insurance benefits for months after December 1990 for which applications are filed on or after January 1, 1991, or are pending on such date.

[64] See Vol. II, P.L. 88-525, §11(i) and (j), with respect to accepting applications for food stamps at Social Security Administration offices.

See Vol. II, P.L. 95-216, §334(g), where government service is involved.

(i) the child referred to in subparagraph (E) is his or her son, daughter, or legally adopted child, and

(ii) the benefits referred to in such subparagraph are payable on the basis of such individual's wages and self-employment income,

shall (subject to subsection (s)) be entitled to a mother's or father's insurance benefit for each month, beginning with the first month in which he or she becomes so entitled to such insurance benefits and ending with the month preceding the first month in which any of the following occurs: no child of such deceased individual is entitled to a child's insurance benefit, such surviving spouse or surviving divorced parent becomes entitled to an old-age insurance benefit equal to or exceeding three-fourths of the primary insurance amount of such deceased individual, he or she becomes entitled to a surviving spouse's insurance benefit, he or she remarries, or he or she dies. Entitlement to such benefits shall also end, in the case of a surviving divorced parent, with the month immediately preceding the first month in which no son, daughter, or legally adopted child of such surviving divorced parent is entitled to a child's insurance benefit on the basis of the wages and self-employment income of such deceased individual.

(2) Except as provided in paragraph (4) of this subsection, such mother's or father's insurance benefit for each month shall be equal to three-fourths of the primary insurance amount of such deceased individual.

(3) In the case of a surviving spouse or surviving divorced parent who marries—

(A) an individual entitled to benefits under this subsection or subsection (a), (b), (c), (e), (f), or (h), or under section 223(a), or

(B) an individual who has attained the age of eighteen and is entitled to benefits under subsection (d),

the entitlement of such surviving spouse or surviving divorced parent to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) but subject to subsection (s), not be terminated by reason of such marriage.

(4)(A) The amount of a mother's or father's insurance benefit for each month (as determined after application of the provisions of subsection (k)) shall be reduced (but not below zero) by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to the individual for such month which is based upon the individual's earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2)) if, on the last day the individual was employed by such entity—

(i) such service did not constitute "employment" as defined in section 210, or[65]

(ii) such service was being performed while in the service of the Federal Government, and constituted "employment" as so defined solely by reason of—

(I) clause (ii) or (iii) of subparagraph (G) of section 210(a)(5), where the lump-sum payment described in such clause (ii) or the cessation of coverage described in such clause (iii)

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[65] See Vol. II, P.L. 100-647, §8014(b), with respect to clarification of applicability of government pension offset to certain Federal employees.

(whichever is applicable) was received or occurred on or after January 1, 1988, or

(II) an election to become subject to the Federal Employees' Retirement System provided in chapter 84 of title 5, United States Code, or the Foreign Service Pension System provided in subchapter II of chapter 8 of title I of the Foreign Service Act of 1980 made pursuant to law after December 31, 1987,

unless subparagraph (B) applies.

The amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10.

(B) Subparagraph (A)(ii) shall not apply with respect to monthly periodic benefits based in whole or in part on service which constituted "employment" as defined in section 210 if such service was performed for at least 60 months in the aggregate during the period beginning January 1, 1988, and ending with the close of the first calendar month as of the end of which the individual is eligible for benefits under this subsection and has made a valid application for such benefits.

(C) For purposes of this paragraph, any periodic benefit which otherwise meets the requirements of subparagraph (A), but which is paid on other than a monthly basis, shall be allocated on a basis equivalent to a monthly benefit (as determined by the Secretary) and such equivalent monthly benefit shall constitute a monthly periodic benefit for purposes of subparagraph (A). For purposes of this subparagraph, the term "periodic benefit" includes a benefit payable in a lump sum if it is a commutation of, or a substitute for, periodic payments.

Parent's Insurance Benefits[66]

(h)(1) Every parent (as defined in this subsection) of an individual who died a fully insured individual, if such parent—

(A) has attained age 62,

(B)(i) was receiving at least one-half of his support from such individual at the time of such individual's death or, if such individual had a period of disability which did not end prior to the month in which he died, at the time such period began or at the time of such death, and (ii) filed proof of such support within two years after the date of such death, or, if such individual had such a period of disability, within two years after the month in which such individual filed application with respect to such period of disability or two years after the date of such death, as the case may be,

(C) has not married since such individual's death,

(D) is not entitled to old-age insurance benefits, or is entitled to old-age insurance benefits each of which is less than 82 1/2 percent of the primary insurance amount of such deceased individual if the amount of the parent's insurance benefit for such month is determinable under paragraph (2)(A) (or 75 percent of such primary insurance amount in any other case), and

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[66] See Vol. II, P.L. 88-525, §11(i) and (j), with respect to accepting applications for food stamps at Social Security Administration offices.

(E) has filed application for parent's insurance benefits,

shall be entitled to a parent's insurance benefit for each month beginning with the first month after August 1950 in which such parent becomes so entitled to such parent's insurance benefits and ending with the month preceding the first month in which any of the following occurs: such parent dies, marries, or becomes entitled to an old-age insurance benefit equal to or exceeding 82 1/2 percent of the primary insurance amount of such deceased individual if the amount of the parent's insurance benefit for such month is determinable under paragraph (2)(A) (or 75 percent of such primary insurance amount in any other case).

(2)(A) Except as provided in subparagraphs (B) and (C), such parent's insurance benefit for each month shall be equal to 82 1/2 percent of the primary insurance amount of such deceased individual.

(B) For any month for which more than one parent is entitled to parent's insurance benefits on the basis of such deceased individual's wages and self-employment income, such benefit for each such parent for such month shall (except as provided in subparagraph (C)) be equal to 75 percent of the primary insurance amount of such deceased individual.

(C) In any case in which—

(i) any parent is entitled to a parent's insurance benefit for a month on the basis of a deceased individual's wages and self-employment income, and

(ii) another parent of such deceased individual is entitled to a parent's insurance benefit for such month on the basis of such wages and self-employment income, and on the basis of an application filed after such month and after the month in which the application for the parent's benefits referred to in clause (i) was filed,

the amount of the parent's insurance benefit of the parent referred to in clause (i) for the month referred to in such clause shall be determined under subparagraph (A) instead of subparagraph (B) and the amount of the parent's insurance benefit of a parent referred to in clause (ii) for such month shall be equal to 150 percent of the primary insurance amount of the deceased individual minus the amount (before the application of section 203(a)) of the benefit for such month of the parent referred to in clause (i).

(3) As used in this subsection, the term "parent" means the mother or father of an individual, a stepparent of an individual by a marriage contracted before such individual attained the age of sixteen, or an adopting parent by whom an individual was adopted before he attained the age of sixteen.

(4) In the case of a parent who marries—

(A) an individual entitled to benefits under this subsection or subsection (b), (c), (e), (f), or (g), or

(B) an individual who has attained the age of eighteen and is entitled to benefits under subsection (d),

such parent's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) but subject to subsection (s), not be terminated by reason of such marriage.

Lump-Sum Death Payments

(i) Upon the death, after August 1950, of an individual who died a fully or currently insured individual, an amount equal to three times such individual's primary insurance amount (as determined without regard to the amendments made by section 2201 of the Omnibus Budget Reconciliation Act of 1981[67], relating to the repeal of the minimum benefit provisions), or an amount equal to $255, whichever is the smaller, shall be paid in a lump sum to the person, if any, determined by the Secretary to be the widow or widower of the deceased and to have been living in the same household with the deceased at the time of death. If there is no such person, or if such person dies before receiving payment, then such amount shall be paid—

> (1) to a widow (as defined in section 216(c)) or widower (as defined in section 216(g)) who is entitled (or would have been so entitled had a timely application been filed), on the basis of the wages and self-employment income of such insured individual, to benefits under subsection (e), (f), or (g) of this section for the month in which occurred such individual's death; or
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> (2) if no person qualifies for payment under paragraph (1), or if such person dies before receiving payment, in equal shares to each person who is entitled (or would have been so entitled had a timely application been filed), on the basis of the wages and self-employment income of such insured individual, to benefits under subsection (d) of this section for the month in which occurred such individual's death.

No payment shall be made to any person under this subsection unless application therefor shall have been filed, by or on behalf of such person (whether or not legally competent), prior to the expiration of two years after the date of death of such insured individual, or unless such person was entitled to wife's or husband's insurance benefits, on the basis of the wages and self-employment income of such insured individual, for the month preceding the month in which such individual died. In the case of any individual who died outside the forty-eight States and the District of Columbia after December 1953 and before January 1, 1957, whose death occurred while he was in the active military or naval service of the United States, and who is returned to any of such States, the District of Columbia, Alaska, Hawaii, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa for interment or reinterment, the provisions of the preceding sentence shall not prevent payment to any person under the second sentence of this subsection if application for a lump-sum death payment with respect to such deceased individual is filed by or on behalf of such person (whether or not legally competent) prior to the expiration of two years after the date of such interment or reinterment. In the case of any individual who died outside the fifty States and the District of Columbia after December 1956 while he was performing service, as a member of a uniformed service, to which the provisions of section 210(l)(1) are applicable, and who is returned to any State, or to any Territory or possession of the United States, for interment or reinterment, the provisions of the third sentence of this subsection shall not prevent payment to any person under the second sentence of this subsection if application for a lump-sum death payment with respect to such deceased individual is filed by or on behalf of such person (whether or not legally competent) prior to the expiration of two years after the date of such interment or reinterment.

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[67] P.L. 97-35.

Application for Monthly Insurance Benefits

(j)(1) Subject to the limitations contained in paragraph (4), an individual who would have been entitled to a benefit under subsection (a), (b), (c), (d), (e), (f), (g), or (h) for any month after August 1950 had he filed application therefor prior to the end of such month shall be entitled to such benefit for such month if he files application therefor prior to—

(A) the end of the twelfth month immediately succeeding such month in any case where the individual (i) is filing application for a benefit under subsection (e) or (f), and satisfies paragraph (1)(B) of such subsection by reason of clause (ii) thereof, or (ii) is filing application for a benefit under subsection (b), (c), or (d) on the basis of the wages and self-employment income of a person entitled to disability insurance benefits, or

(B) the end of the sixth month immediately succeeding such month in any case where subparagraph (A) does not apply.

Any benefit under this title for a month prior to the month in which application is filed shall be reduced, to any extent that may be necessary, so that it will not render erroneous any benefit which, before the filing of such application, the Secretary has certified for payment for such prior month.

(2) An application for any monthly benefits under this section filed before the first month in which the applicant satisfies the requirements for such benefits shall be deemed a valid application (and shall be deemed to have been filed in such first month) only if the applicant satisfies the requirements for such benefits before the Secretary makes a final decision on the application and no request under section 205(b) for notice and opportunity for a hearing thereon is made or, if such a request is made, before a decision based upon the evidence adduced at the hearing is made (regardless of whether such decision becomes the final decision of the Secretary).

(3) Notwithstanding the provisions of paragraph (1), an individual may, at his option, waive entitlement to any benefit referred to in paragraph (1) for any one or more consecutive months (beginning with the earliest month for which such individual would otherwise be entitled to such benefit) which occur before the month in which such individual files application for such benefit; and, in such case, such individual shall not be considered as entitled to such benefits for any such month or months before such individual filed such application. An individual shall be deemed to have waived such entitlement for any such month for which such benefit would, under the second sentence of paragraph (1), be reduced to zero.

(4)(A) Except as provided in subparagraph (B), no individual shall be entitled to a monthly benefit under subsection (a), (b), (c), (e), or (f) for any month prior to the month in which he or she files an application for benefits under that subsection if the amount of the monthly benefit to which such individual would otherwise be entitled for any such month would be subject to reduction pursuant to subsection (q).[68]

(B)[69] (i)[70] If the individual applying for retroactive benefits is a widow, surviving divorced wife, or widower and is under a disability (as defined in section 223(d)), and such individual would, except for subparagraph (A), be entitled to retroactive benefits as a disabled widow or widower or disabled surviving divorced wife for any month before attaining the age of 60, then subparagraph (A) shall not apply with respect to such month or any subsequent month.

(ii)[71] Subparagraph (A) does not apply to a benefit under subsection (e) or (f) for the month immediately preceding the month of application, if the insured individual died in that preceding month.

(iii)[72] As used in this subparagraph, the term "retroactive benefits" means benefits to which an individual becomes entitled for a month prior to the month in which application for such benefits is filed.

(5) In any case in which it is determined to the satisfaction of the Secretary that an individual failed as of any date to apply for monthly insurance benefits under this title by reason of misinformation provided to such individual by any officer or employee of the Social Security Administration relating to such individual's eligibility for benefits under this title, such individual shall be deemed to have applied for such benefits on the later of—

(A) the date on which such misinformation was provided to such individual, or

(B) the date on which such individual met all requirements for entitlement to such benefits (other than application therefor).[73]

Simultaneous Entitlement to Benefits

(k)(1) A child, entitled to child's insurance benefits on the basis of the wages and self-employment income of an insured individual, who would be entitled, on filing application, to child's insurance benefits on the basis of the wages and self-employment income of some other insured individual, shall be deemed entitled, subject to the provisions of paragraph (2) hereof, to child's insurance benefits on the basis of the wages and self-employment income of such other individual if an application for child's insurance benefits on the basis of the wages and self-employment income of such other individual has been filed by any other child who would, on filing application, be entitled to child's insurance benefits on the basis of the wages and self-employment income of both such insured individuals.

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[68] P.L. 101-508, §5116(a)(1), struck out "effect of entitlement to such benefit would be to reduce, pursuant to subsection (q), the amount of the monthly benefit to which such individual would otherwise be entitled for the month in which such application is filed.", and substituted "amount of the monthly benefit to which such individual would otherwise be entitled for any such month would be subject to reduction pursuant to subsection (q).", applicable to applications for benefits filed on or after January 1, 1991.

[69] P.L. 101-508, §5116(a)(2), struck out clause (i). [For clause (i) as it formerly read, see Vol. III, P.L. 101-508.]

[70] P.L. 101-508, §5116(a)(2), redesignated clause (ii) as clause (i), applicable to applications for benefits filed on or after January 1, 1991.

[71] P.L. 101-508, §5116(a)(2), redesignated clause (iii) as clause (ii).

[72] P.L. 101-508, §5116(a)(2), struck out clause (iv), applicable to applications for benefits filed on or after January 1, 1991. [For clause (iv) as it formerly read, see Vol. III, P.L. 101-508.]

P.L. 101-508, §5116(a)(2), redesignated clause (v) as clause (iii).

[73] P.L. 101-239, §10302(a)(1), added paragraph (5), applicable with respect to misinformation furnished after December 1982 and to benefits for months after December 1982.

(2)(A) Any child who under the preceding provisions of this section is entitled for any month to child's insurance benefits on the wages and self-employment income of more than one insured individual shall, notwithstanding such provisions, be entitled to only one of such child's insurance benefits for such month. Such child's insurance benefits for such month shall be the benefit based on the wages and self-employment income of the insured individual who has the greatest primary insurance amount, except that such child's insurance benefits for such month shall be the largest benefit to which such child could be entitled under subsection (d) (without the application of section 203(a)) or subsection (m) if entitlement to such benefit would not, with respect to any person, result in a benefit lower (after the application of section 203(a)) than the benefit which would be applicable if such child were entitled on the wages and self-employment income of the individual with the greatest primary insurance amount. Where more than one child is entitled to child's insurance benefits pursuant to the preceding provisions of this paragraph, each such child who is entitled on the wages and self-employment income of the same insured individuals shall be entitled on the wages and self-employment income of the same such insured individual.

(B) Any individual (other than an individual to whom subsection (e)(3) or (f)(4) applies) who, under the preceding provisions of this section and under the provisions of section 223, is entitled for any month to more than one monthly insurance benefit (other than an old-age or disability insurance benefit) under this title shall be entitled to only one such monthly benefit for such month, such benefit to be the largest of the monthly benefits to which he (but for this subparagraph (B)) would otherwise be entitled for such month. Any individual who is entitled for any month to more than one widow's or widower's insurance benefit to which subsection (e)(3) or (f)(4) applies shall be entitled to only one such benefit for such month, such benefit to be the largest of such benefits.

(3)(A) If an individual is entitled to an old-age or disability insurance benefit for any month and to any other monthly insurance benefit for such month, such other insurance benefit for such month, after any reduction under subsection (q), subsection (e)(2) or (f)(3), and any reduction under section 203(a), shall be reduced, but not below zero, by an amount equal to such old-age or disability insurance benefit (after reduction under such subsection (q)).

(B) If an individual is entitled for any month to a widow's or widower's insurance benefit to which subsection (e)(3) or (f)(4) applies and to any other monthly insurance benefit under section 202 (other than an old-age insurance benefit), such other insurance benefit for such month, after any reduction under subparagraph (A), any reduction under subsection (q), and any reduction under section 203(a), shall be reduced, but not below zero, by an amount equal to such widow's or widower's insurance benefit after any reduction or reductions under such subparagraph (A) and such section 203(a).

(4) Any individual who, under this section and section 223, is entitled for any month to both an old-age insurance benefit and a disability insurance benefit under this title shall be entitled to only the larger of such benefits for such month, except that, if such individual so elects, he shall instead be entitled to only the smaller of such benefits for such month.

Entitlement to Survivor Benefits Under Railroad Retirement Act

(l)If any person would be entitled, upon filing application therefor to an annuity under section 2 of the Railroad Retirement Act of 1974[74], or to a lump-sum payment under section 6(b) of such Act, with respect to the death of an employee (as defined in such Act) no lump-sum death payment, and no monthly benefit for the month in which such employee died or for any month thereafter, shall be paid under this section to any person on the basis of the wages and self-employment income of such employee.

[(m)Repealed.[75]]

Termination of Benefits Upon Deportation of Primary Beneficiary

(n)(1) If any individual is (after the date of enactment of this subsection[76]) deported under under[77] section 241(a) (other than under paragraph (1)(C) or (1)(E) thereof) [78] of the Immigration and Nationality Act[79], then, notwithstanding any other provisions of this title —

(A) no monthly benefit under this section or section 223 shall be paid to such individual, on the basis of his wages and self-employment income, for any month occurring (i) after the month in which the Secretary is notified by the Attorney General that such individual has been so deported, and (ii) before the month in which such individual is thereafter lawfully admitted to the United States for permanent residence,

(B) if no benefit could be paid to such individual (or if no benefit could be paid to him if he were alive) for any month by reason of subparagraph (A), no monthly benefit under this section shall be paid, on the basis of his wages and self-employment income, for such month to any other person who is not a citizen of the United States and is outside the United States for any part of such month, and

(C) no lump-sum death payment shall be made on the basis of such individual's wages and self-employment income if he dies (i) in or after the month in which such notice is received, and (ii) before the month in which he is thereafter lawfully admitted to the United States for permanent residence.

Section 203(b), (c), and (d) of this Act shall not apply with respect to any such individual for any month for which no monthly benefit may be paid to him by reason of this paragraph.

(2) As soon as practicable after the deportation of any individual under any of the paragraphs of section 241(a) of the Immigration and Nationality Act (other than under paragraph (1)(C) or (1)(E) thereof)[80], the Attorney General shall notify the Secretary of such deportation.

(3) For purposes of paragraphs (1) and (2) of this subsection, an individual against whom a final order of deportation has been issued

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[74] P.L. 75- 162 [as amended by P.L. 93-445].

[75] P.L. 97-35, §2201(b)(10); 95 Stat. 831; P.L. 97-123, §2(j)(1); 95 Stat. 1661.

[76] September 1, 1954 [P.L. 83-761, §107; 68 Stat. 1083].

[77] As in original.

[78] P.L. 101-649, §603(b)(5)(A), struck out "paragraph (1), (2), (4), (5), (6), (7), (10), (11), (12), (14), (15), (16), (17), or (18)* of section 241(a)" and substituted "under section 241(a) (other than under paragraph (1)(C) or (1)(E) thereof)", effective November 29, 1990. *Probably should read "(17), (18), or (19)".

[79] P.L. 82-414.

[80] P.L. 101-649, §603(b)(5)(B), struck out "enumerated in paragraph (1) in this subsection" and substituted "(other than under paragraph (1)(C) or (1)(E) thereof)", effective November 29, 1990.

under paragraph (19) of section 241(a) of the Immigration and Nationality Act (relating to persecution of others on account of race, religion, national origin, or political opinion, under the direction of or in association with the Nazi government of Germany or its allies) shall be considered to have been deported under such paragraph (19) as of the date on which such order became final.

Application for Benefits by Survivors of Members and Former Members of the Uniformed Services

(o) In the case of any individual who would be entitled to benefits under subsection (d), (e), (g), or (h) upon filing proper application therefor, the filing with the Administrator of Veterans' Affairs by or on behalf of such individual of an application for such benefits, on the form described in section 3005 of title 38, United States Code, shall satisfy the requirement of such subsection (d), (e), (g), or (h) that an application for such benefits be filed.

Extension of Period for Filing Proof of Support and Applications for Lump-Sum Death Payment

(p) In any case in which there is a failure—

(1) to file proof of support under subparagraph (B) of subsection (h)(1), or under clause (B) of subsection (f)(1) of this section as in effect prior to the Social Security Act Amendments of 1950[81], within the period prescribed by such subparagraph or clause, or

(2) to file, in the case of a death after 1946, application for a lump-sum death payment under subsection (i), or under subsection (g) of this section as in effect prior to the Social Security Act Amendments of 1950, within the period prescribed by such subsection,

any such proof or application, as the case may be, which is filed after the expiration of such period shall be deemed to have been filed within such period if it is shown to the satisfaction of the Secretary that there was good cause for failure to file such proof or application within such period. The determination of what constitutes good cause for purposes of this subsection shall be made in accordance with regulations of the Secretary.

Reduction of Benefit Amounts for Certain Beneficiaries

(q)(1) Subject to paragraph (9), if the first month for which an individual is entitled to an old-age, wife's, husband's, widow's, or widower's insurance benefit is a month before the month in which such individual attains retirement age, the amount of such benefit for such month and for any subsequent month shall, subject to the succeeding paragraphs of this subsection, be reduced by—

(A) 5/9 of 1 percent of such amount if such benefit is an old-age insurance benefit, 25/36 of 1 percent of such amount if such benefit is a wife's or husband's insurance benefit, or 19/40 of 1 percent of such amount if such benefit is a widow's or widower's insurance benefit, multiplied by—[82]

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[81] P.L. 81-734.

[82] As in original.

(B)(i) the number of months in the reduction period for such benefit (determined under paragraph (6)), if such benefit is for a month before the month in which such individual attains retirement age, or

(ii) if less, the number of such months in the adjusted reduction period for such benefit (determined under paragraph (7)), if such benefit is (I) for the month in which such individual attains age 62, or (II) for the month in which such individual attains retirement age.

(2) If an individual is entitled to a disability insurance benefit for a month after a month for which such individual was entitled to an old-age insurance benefit, such disability insurance benefit for each month shall be reduced by the amount such old-age insurance benefit would be reduced under paragraphs (1) and (4) for such month had such individual attained retirement age (as defined in section 216(l)) in the first month for which he most recently became entitled to a disability insurance benefit.

(3)(A) If the first month for which an individual both is entitled to a wife's, husband's, widow's, or widower's insurance benefit and has attained age 62 (in the case of a wife's or husband's insurance benefit) or age 50 (in the case of a widow's or widower's insurance benefit) is a month for which such individual is also entitled to—

(i) an old-age insurance benefit (to which such individual was first entitled for a month before he attains retirement age (as defined in section 216(l))), or

(ii) a disability insurance benefit,

then in lieu of any reduction under paragraph (1) (but subject to the succeeding paragraphs of this subsection) such wife's, husband's, widow's, or widower's insurance benefit for each month shall be reduced as provided in subparagraph (B), (C), or (D).

(B) For any month for which such individual is entitled to an old-age insurance benefit and is not entitled to a disability insurance benefit, such individual's wife's or husband's insurance benefit shall be reduced by the sum of—

(i) the amount by which such old-age insurance benefit is reduced under paragraph (1) for such month, and

(ii) the amount by which such wife's or husband's insurance benefit would be reduced under paragraph (1) for such month if it were equal to the excess of such wife's or husband's insurance benefit (before reduction under this subsection) over such old-age insurance benefit (before reduction under this subsection).

(C) For any month for which such individual is entitled to a disability insurance benefit, such individual's wife's, husband's, widow's, or widower's insurance benefit shall be reduced by the sum of—

(i) the amount by which such disability insurance benefit is reduced under paragraph (2) for such month (if such paragraph applied to such benefit), and

(ii) the amount by which such wife's, husband's, widow's, or widower's insurance benefit would be reduced under paragraph (1) for such month if it were equal to the excess of such wife's, husband's, widow's, or widower's insurance benefit (before reduction under this subsection) over such disability insurance benefit (before reduction under this subsection).

(D) For any month for which such individual is entitled neither to an old-age insurance benefit nor to a disability insurance benefit, such individual's wife's, husband's, widow's, or widower's insurance benefit shall be reduced by the amount by which it would be reduced under paragraph (1).[83]

(E)[84] Notwithstanding subparagraph (A) of this paragraph, if the first month for which an individual is entitled to a widow's or widower's insurance benefit is a month for which such individual is also entitled to an old-age insurance benefit to which such individual was first entitled for that month or for a month before she or he became entitled to a widow's or widower's benefit, the reduction in such widow's or widower's insurance benefit shall be determined under paragraph (1).

(4) If—

(A) an individual is or was entitled to a benefit subject to reduction under paragraph (1) or (3) of this subsection, and

(B) such benefit is increased by reason of an increase in the primary insurance amount of the individual on whose wages and self-employment income such benefit is based,

then the amount of the reduction of such benefit (after the application of any adjustment under paragraph (7)) for each month beginning with the month of such increase in the primary insurance amount shall be computed under paragraph (1) or (3), whichever applies, as though the increased primary insurance amount had been in effect for and after the month for which the individual first became entitled to such monthly benefit reduced under such paragraph (1) or (3).

(5)(A) No wife's or husband's insurance benefit shall be reduced under this subsection—

(i) for any month before the first month for which there is in effect a certificate filed by him or her with the Secretary, in accordance with regulations prescribed by the Secretary, in which he or she elects to receive wife's or husband's insurance benefits reduced as provided in this subsection, or

(ii) for any month in which he or she has in his or her care (individually or jointly with the person on whose wages and self-employment income the wife's or husband's insurance benefit is based) a child of such person entitled to child's insurance benefits.

(B) Any certificate described in subparagraph (A)(i) shall be effective for purposes of this subsection (and for purposes of preventing deductions under section 203(c)(2))—

(i) for the month in which it is filed and for any month thereafter, and

(ii) for months, in the period designated by the individual filing such certificate, of one or more consecutive months (not exceeding 12) immediately preceding the month in which such certificate is filed;

except that such certificate shall not be effective for any month before the month in which he or she attains age 62, nor shall it be effective for any month to which subparagraph (A)(ii) applies.

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[83] P.L. 101-239, §10203(a)(1), struck out subparagraphs (E), (F), and (G). For the effective date, see Vol. II, P.L. 101-239, §10203(b). [For subparagraphs (E), (F), and (G) as they formerly read, see Vol. III, P.L. 101-239.]

[84] P.L. 101-239, §10203(a)(2), redesignated subparagraph (H) as subparagraph (E). For the effective date, see Vol. II, P.L. 101-239, §10203(b).

(C) If an individual does not have in his or her care a child described in subparagraph (A)(ii) in the first month for which he or she is entitled to a wife's or husband's insurance benefit, and if such first month is a month before the month in which he or she attains retirement age (as defined in section 216(l)), he or she shall be deemed to have filed in such first month the certificate described in subparagraph (A)(i).

(D) No widow's or widower's insurance benefit for a month in which he or she has in his or her care a child of his or her deceased spouse (or deceased former spouse) entitled to child's insurance benefits shall be reduced under this subsection below the amount to which he or she would have been entitled had he or she been entitled for such month to mother's or father's insurance benefits on the basis of his or her deceased spouse's (or deceased former spouse's) wages and self-employment income.

(6) For purposes of this subsection, the "reduction period" for an individual's old-age, wife's, husband's, widow's, or widower's insurance benefit is the period—

(A) beginning—

(i) in the case of an old-age insurance benefit, with the first day of the first month for which such individual is entitled to such benefit,

(ii) in the case of a wife's or husband's insurance benefit, with the first day of the first month for which a certificate described in paragraph (5)(A)(i) is effective, or

(iii) in the case of a widow's or widower's insurance benefit, with the first day of the first month for which such individual is entitled to such benefit or the first day of the month in which such individual attains age 60, whichever is the later, and

(B) ending with the last day of the month before the month in which such individual attains retirement age.

(7) For purposes of this subsection, the "adjusted reduction period" for an individual's old-age, wife's, husband's, widow's, or widower's insurance benefit is the reduction period prescribed in paragraph (6) for such benefit, excluding—

(A) any month in which such benefit was subject to deductions under section 203(b), 203(c)(1), 203(d)(1), or 222(b),

(B) in the case of wife's or husband's insurance benefits, any month in which such individual had in his or her care (individually or jointly with the person on whose wages and self-employment income such benefit is based) a child of such person entitled to child's insurance benefits,

(C) in the case of wife's or husband's insurance benefits, any month for which such individual was not entitled to such benefits because of the occurrence of an event that terminated her or his entitlement to such benefits,

(D) in the case of widow's or widower's insurance benefits, any month in which the reduction in the amount of such benefit was determined under paragraph (5)(D),

(E) in the case of widow's or widower's insurance benefits, any month before the month in which she or he attained age 62, and also for any later month before the month in which she or he attained retirement age, for which she or he was not entitled to such benefit because of the occurrence of an event that terminated her or his entitlement to such benefits, and

(F) in the case of old-age insurance benefits, any month for which such individual was entitled to a disability insurance benefit.

(8) This subsection shall be applied after reduction under section 203(a) and before application of section 215(g). If the amount of any reduction computed under paragraph (1), (2), or (3) is not a multiple of $0.10, it shall be increased to the next higher multiple of $0.10.

(9) The amount of the reduction for early retirement specified in paragraph (1)—

(A) for old-age insurance benefits, wife's insurance benefits, and husband's insurance benefits, shall be the amount specified in such paragraph for the first 36 months of the reduction period (as defined in paragraph (6)) or adjusted reduction period (as defined in paragraph (7)), and five-twelfths of 1 percent for any additional months included in such periods; and

(B) for widow's insurance benefits and widower's insurance benefits, shall be periodically revised by the Secretary such that—

(i) the amount of the reduction at early retirement age as defined in section 216(l) shall be 28.5 percent of the full benefit; and

(ii) the amount of the reduction for each month in the reduction period (specified in paragraph (6)) or the adjusted reduction period (specified in paragraph (7)) shall be established by linear interpolation between 28.5 percent at the month of attainment of early retirement age and 0 percent at the month of attainment of retirement age.

(10) For purposes of applying paragraph (4), with respect to monthly benefits payable for any month after December 1977 to an individual who was entitled to a monthly benefit as reduced under paragraph (1) or (3) prior to January 1978, the amount of reduction in such benefit for the first month for which such benefit is increased by reason of an increase in the primary insurance amount of the individual on whose wages and self-employment income such benefit is based and for all subsequent months (and similarly for all subsequent increases) shall be increased by a percentage equal to the percentage increase in such primary insurance amount (such increase being made in accordance with the provisions of paragraph (8)). In the case of an individual whose reduced benefit under this section is increased as a result of the use of an adjusted reduction period (in accordance with paragraphs (1) and (3) of this subsection), then for the first month for which such increase is effective, and for all subsequent months, the amount of such reduction (after the application of the previous sentence, if applicable) shall be determined—

(A) in the case of old-age, wife's, and husband's insurance benefits, by multiplying such amount by the ratio of (i) the number of months in the adjusted reduction period to (ii) the number of months in the reduction period,

(B) in the case of widow's and widower's insurance benefits for the month in which such individual attains age 62, by multiplying such amount by the ratio of (i) the number of months in the reduction period beginning with age 62 multiplied by 19/40 of 1 percent, plus the number of months in the adjusted reduction period prior to age 62 multiplied by 19/40 of 1 percent to (ii) the number of months in the reduction period multiplied by 19/40 of 1 percent, and

(C) in the case of widow's and widower's insurance benefits for the month in which such individual attains retirement age (as defined in section 216(l)), by multiplying such amount by the ratio of (i) the number of months in the adjusted reduction period multiplied by 19/40 of 1 percent to (ii) the number of months in the reduction period beginning with age 62 multiplied by 19/40 of 1 percent, plus the number of months in the adjusted reduction period prior to age 62 multiplied by 19/40 of 1 percent,

such determination being made in accordance with the provisions of paragraph (8).

(11) When an individual is entitled to more than one monthly benefit under this title and one or more of such benefits are reduced under this subsection, paragraph (10) shall apply separately to each such benefit reduced under this subsection before the application of subsection (k) (pertaining to the method by which monthly benefits are offset when an individual is entitled to more than one kind of benefit) and the application of this paragraph shall operate in conjunction with paragraph (3).

Presumed Filing of Application by Individuals Eligible for Old-Age Insurance Benefits and for Wife's or Husband's Insurance Benefits

(r)(1) If the first month for which an individual is entitled to an old-age insurance benefit is a month before the month in which such individual attains retirement age (as defined in section 216(l)), and if such individual is eligible for a wife's or husband's insurance benefit for such first month, such individual shall be deemed to have filed an application in such month for wife's or husband's insurance benefits.

(2) If the first month for which an individual is entitled to a wife's or husband's insurance benefit reduced under subsection (q) is a month before the month in which such individual attains retirement age (as defined in section 216(l)), and if such individual is eligible (but for section 202(k)(4)) for an old-age insurance benefit for such first month, such individual shall be deemed to have filed an application for old-age insurance benefits—

(A) in such month, or

(B) if such individual is also entitled to a disability insurance benefit for such month, in the first subsequent month for which such individual is not entitled to a disability insurance benefit.

(3) For purposes of this subsection, an individual shall be deemed eligible for a benefit for a month if, upon filing application therefor in such month, he would be entitled to such benefit for such month.

Child Over Specified Age to be Disregarded for Certain Benefit Purposes Unless Disabled

(s)(1) For the purposes of subsections (b)(1), (c)(1), (g)(1), (q)(5), and (q)(7) of this section and paragraphs (2), (3), and (4) of section 203(c), a child who is entitled to child's insurance benefits under subsection (d) for any month, and who has attained the age of 16 but is not in such month under a disability (as defined in section 223(d)), shall be deemed not entitled to such benefits for such month, unless he was under such a disability in the third month before such month.

(2) So much of subsections (b)(3), (c)(4), (d)(5), (g)(3), and (h)(4) of this section as precedes the semicolon, shall not apply in the case of any child unless such child, at the time of the marriage referred to therein, was under a disability (as defined in section 223(d)) or had been under such a disability in the third month before the month in which such marriage occurred.

(3) The last sentence of subsection (c) of section 203, subsection (f)(1)(C) of section 203, and subsections (b)(3)(B), (c)(6)(B), (f)(3)(B), and (g)(6)(B) of section 216 shall not apply in the case of any child with respect to any month referred to therein unless in such month or the third month prior thereto such child was under a disability (as defined in section 223(d)).

Suspension of Benefits of Aliens Who Are Outside the United States; Residency Requirements for Dependents and Survivors

(t)(1) Notwithstanding any other provision of this title, no monthly benefits shall be paid under this section or under section 223 to any individual who is not a citizen or national of the United States for any month which is—

(A) after the sixth consecutive calendar month during all of which the Secretary finds, on the basis of information furnished to him by the Attorney General or information which otherwise comes to his attention, that such individual is outside the United States, and

(B) prior to the first month thereafter for all of which such individual has been in the United States.

For purposes of the preceding sentence, after an individual has been outside the United States for any period of thirty consecutive days he shall be treated as remaining outside the United States until he has been in the United States for a period of thirty consecutive days.

(2) Subject to paragraph (11), paragraph (1) shall not apply to any individual who is a citizen of a foreign country which the Secretary finds has in effect a social insurance or pension system which is of general application in such country and under which—

(A) periodic benefits, or the actuarial equivalent thereof, are paid on account of old age, retirement, or death, and

(B) individuals who are citizens of the United States but not citizens of such foreign country and who qualify for such benefits are permitted to receive such benefits or the actuarial equivalent thereof while outside such foreign country without regard to the duration of the absence.

(3) Paragraph (1) shall not apply in any case where its application would be contrary to any treaty obligation of the United States in effect on the date of the enactment of this subsection[85].

(4) Subject to paragraph (11), paragraph (1) shall not apply to any benefit for any month if—

(A) not less than forty of the quarters elapsing before such month are quarters of coverage for the individual on whose wages and self-employment income such benefit is based, or

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[85] August 1, 1956 [P.L. 84-880, §118(a); 70 Stat. 835, 856].

(B) the individual on whose wages and self-employment income such benefit is based has, before such month, resided in the United States for a period or periods aggregating ten years or more, or

(C) the individual entitled to such benefit is outside the United States while in the active military or naval service of the United States, or

(D) the individual on whose wages and self-employment income such benefit is based died, before such month, either (i) while on active duty or inactive duty training (as those terms are defined in section 210(l)(2) and (3)) as a member of a uniformed service (as defined in section 210(m)), or (ii) as the result of a disease or injury which the Administrator of Veterans' Affairs determines was incurred or aggravated in line of duty while on active duty (as defined in section 210(l)(2)), or an injury which he determines was incurred or aggravated in line of duty while on inactive duty training (as defined in section 210(l)(3)), as a member of a uniformed service (as defined in section 210(m)), if the Administrator determines that such individual was discharged or released from the period of such active duty or inactive duty training under conditions other than dishonorable, and if the Administrator certifies to the Secretary his determinations with respect to such individual under this clause, or

(E) the individual on whose employment such benefit is based had been in service covered by the Railroad Retirement Act of 1937 or 1974[86] which was treated as employment covered by this Act pursuant to the provisions of section 5(k)(1) of the Railroad Retirement Act of 1937 or section 18(2) of the Railroad Retirement Act of 1974[87];

except that subparagraphs (A) and (B) of this paragraph shall not apply in the case of any individual who is a citizen of a foreign country that has in effect a social insurance or pension system which is of general application in such country and which satisfies subparagraph (A) but not subparagraph (B) of paragraph (2), or who is a citizen of a foreign country that has no social insurance or pension system of general application if at any time within five years prior to the month in which the Social Security Amendments of 1967 are enacted[88] (or the first month thereafter for which his benefits are subject to suspension under paragraph (1)) payments to individuals residing in such country were withheld by the Treasury Department under the first section of the Act of October 9, 1940 (31 U.S.C. 123)[89].

(5) No person who is, or upon application would be, entitled to a monthly benefit under this section for December 1956 shall be deprived, by reason of paragraph (1), of such benefit or any other benefit based on the wages and self-employment income of the individual on whose wages and self-employment income such monthly benefit for December 1956 is based.

(6) If an individual is outside the United States when he dies and no benefit may, by reason of paragraph (1) or (10), be paid to him for the month preceding the month in which he dies, no lump-sum death

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[86] P.L. 75-162.

[87] See Vol. II, P.L. 75-162, §18(2).

[88] January 2, 1968 [P.L. 90-248; 81 Stat. 821].

[89] P.L. 97-258, §5(b), repealed the Act of October 9, 1940. See, instead, Vol. II, 31 U.S.C. 3329.

payment may be made on the basis of such individual's wages and self-employment income.

(7) Subsections (b), (c), and (d) of section 203 shall not apply with respect to any individual for any month for which no monthly benefit may be paid to him by reason of paragraph (1) of this subsection.

(8) The Attorney General shall certify to the Secretary such information regarding aliens who depart from the United States to any foreign country (other than a foreign country which is territorially contiguous to the continental United States) as may be necessary to enable the Secretary to carry out the purposes of this subsection and shall otherwise aid, assist, and cooperate with the Secretary in obtaining such other information as may be necessary to enable the Secretary to carry out the purposes of this subsection.

(9) No payments shall be made under part A of title XVIII with respect to items or services furnished to an individual in any month for which the prohibition in paragraph (1) against payment of benefits to him is applicable (or would be if he were entitled to any such benefits).

(10) Notwithstanding any other provision of this title, no monthly benefits shall be paid under this section or under section 223, for any month beginning after June 30, 1968, to an individual who is not a citizen or national of the United States and who resides during such month in a foreign country if payments for such month to individuals residing in such country are withheld by the Treasury Department under the first section of the Act of October 9, 1940 (31 U.S.C. 123)[90].

(11)(A) Paragraph (2) and subparagraphs (A), (B), (C), and (E) of paragraph (4) shall apply with respect to an individual's monthly benefits under subsection (b), (c), (d), (e), (f), (g), or (h) only if such individual meets the residency requirements of this paragraph with respect to those benefits.

(B) An individual entitled to benefits under subsection (b), (c), (e), (f), or (g) meets the residency requirements of this paragraph with respect to those benefits only if such individual has resided in the United States, and while so residing bore a spousal relationship to the person on whose wages and self-employment income such entitlement is based, for a total period of not less than 5 years. For purposes of this subparagraph, a period of time for which an individual bears a spousal relationship to another person consists of a period throughout which the individual has been, with respect to such other person, a wife, a husband, a widow, a widower, a divorced wife, a divorced husband, a surviving divorced wife, a surviving divorced husband, a surviving divorced mother, a surviving divorced father, or (as applicable in the course of such period) any two or more of the foregoing.

(C) An individual entitled to benefits under subsection (d) meets the residency requirements of this paragraph with respect to those benefits only if—

(i)(I) such individual has resided in the United States (as the child of the person on whose wages and self-employment income such entitlement is based) for a total period of not less than 5 years, or

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[90] P.L. 97-258, §5(b), repealed the Act of October 9, 1940. See, instead, Vol. II, 31 U.S.C. 3329.

(II) the person on whose wages and self-employment income such entitlement is based, and the individual's other parent (within the meaning of subsection (h)(3)), if any, have each resided in the United States for a total period of not less than 5 years (or died while residing in the United States), and

(ii) in the case of an individual entitled to such benefits as an adopted child, such individual was adopted within the United States by the person on whose wages and self-employment income such entitlement is based, and has lived in the United States with such person and received at least one-half of his or her support from such person for a period (beginning before such individual attained age 18) consisting of—

(I) the year immediately before the month in which such person became eligible for old-age insurance benefits or disability insurance benefits or died, whichever occurred first, or

(II) if such person had a period of disability which continued until he or she became entitled to old-age insurance benefits or disability insurance benefits or died, the year immediately before the month in which such period of disability began.

(D) An individual entitled to benefits under subsection (h) meets the residency requirements of this paragraph with respect to those benefits only if such individual has resided in the United States, and while so residing was a parent (within the meaning of subsection (h)(3)) of the person on whose wages and self-employment income such entitlement is based, for a total period of not less than 5 years.

(E) This paragraph shall not apply with respect to any individual who is a citizen or resident of a foreign country with which the United States has an agreement in force concluded pursuant to section 233, except to the extent provided by such agreement.

Conviction of Subversive Activities, Etc.

(u)(1) If any individual is convicted of any offense (committed after the date of the enactment of this subsection[91]) under—

(A) chapter 37 (relating to espionage and censorship), chapter 105 (relating to sabotage), or chapter 115 (relating to treason, sedition, and subversive activities) of title 18 of the United States Code, or

(B) section 4 of the Internal Security Act of 1950[92], as amended,

then the court may, in addition to all other penalties provided by law, impose a penalty that in determining whether any monthly insurance benefit under this section or section 223 is payable to such individual for the month in which he is convicted or for any month thereafter, in determining the amount of any such benefit payable to such individual for any such month, and in determining whether such individual is entitled to insurance benefits under part A of title XVIII for any such month, there shall not be taken into account—

(C) any wages paid to such individual or to any other individual in the calendar year in which such conviction occurs or in any prior calendar year, and

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[91] August 1, 1956 [P.L. 84-880, §121(a); 70 Stat. 838, 856].

[92] P.L. 81-831.

(D) any net earnings from self-employment derived by such individual or by any other individual during a taxable year in which such conviction occurs or during any prior taxable year.

(2) As soon as practicable after an additional penalty has, pursuant to paragraph (1), been imposed with respect to any individual, the Attorney General shall notify the Secretary of such imposition.

(3) If any individual with respect to whom an additional penalty has been imposed pursuant to paragraph (1) is granted a pardon of the offense by the President of the United States, such additional penalty shall not apply for any month beginning after the date on which such pardon is granted.

Waiver of Benefits

(v)(1) Notwithstanding any other provisions of this title, and subject to paragraph (3), in the case of any individual who files a waiver pursuant to section 1402(g) of the Internal Revenue Code of 1954[93] and is granted a tax exemption thereunder, no benefits or other payments shall be payable under this title to him, no payments shall be made on his behalf under part A of title XVIII, and no benefits or other payments under this title shall be payable on the basis of his wages and self-employment income to any other person, after the filing of such waiver.

(2) Notwithstanding any other provision of this title, and subject to paragraph (3), in the case of any individual who files a waiver pursuant to section 3127 of the Internal Revenue Code of 1986 and is granted a tax exemption thereunder, no benefits or other payments shall be payable under this title to him, no payments shall be made on his behalf under part A of title XVIII, and no benefits or other payments under this title shall be payable on the basis of his wages and self-employment income to any other person, after the filing of such waiver.

(3) If, after an exemption referred to in paragraph (1) or (2) is granted to an individual, such exemption ceases to be effective, the waiver referred to in such paragraph shall cease to be applicable in the case of benefits and other payments under this title and part A of title XVIII to the extent based on—

(A) his wages for and after the calendar year following the calendar year in which occurs the failure to meet the requirements of section 1402(g) or 3127 on which the cessation of such exemption is based, and

(B) his self-employment income for and after the taxable year in which occurs such failure.

Increase in Old-Age Insurance Benefit Amounts on Account of Delayed Retirement[94]

(w)(1) The amount of an old-age insurance benefit (other than a benefit based on a primary insurance amount determined under section 215(a)(3) as in effect in December 1978 or section 215(a)(1)(C)(i) as in effect thereafter) which is payable without regard to this subsection to an individual shall be increased by—

(A) the applicable percentage (as determined under paragraph (6)) of such amount, multiplied by

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[93] See P.L. 83-591, §1402(g); (this volume).

[94] See Vol. II, P.L. 99-177, §255, with respect to exemption of certain benefits from reduction.

(B) the number (if any) of the increment months for such individual.

(2) For purposes of this subsection, the number of increment months for any individual shall be a number equal to the total number of the months—

(A) which have elapsed after the month before the month in which such individual attained retirement age (as defined in section 216(l)) or (if later) December 1970 and prior to the month in which such individual attained age 70, and

(B) with respect to which—

(i) such individual was a fully insured individual (as defined in section 214(a)), and

(ii) such individual either was not entitled to an old-age insurance benefit or suffered deductions under section 203(b) or 203(c) in amounts equal to the amount of such benefit.

(3) For purposes of applying the provisions of paragraph (1), a determination shall be made under paragraph (2) for each year, beginning with 1972, of the total number of an individual's increment months through the year for which the determination is made and the total so determined shall be applicable to such individual's old-age insurance benefits beginning with benefits for January of the year following the year for which such determination is made; except that the total number applicable in the case of an individual who attains age 70 after 1972 shall be determined through the month before the month in which he attains such age and shall be applicable to his old-age insurance benefit beginning with the month in which he attains such age.

(4) This subsection shall be applied after reduction under section 203(a).

(5) If an individual's primary insurance amount is determined under paragraph (3) of section 215(a) as in effect in December 1978, or section 215(a)(1)(C)(i) as in effect thereafter, and, as a result of this subsection, he would be entitled to a higher old-age insurance benefit if his primary insurance amount were determined under section 215(a) (whether before, in, or after December 1978) without regard to such paragraph, such individual's old-age insurance benefit based upon his primary insurance amount determined under such paragraph shall be increased by an amount equal to the difference between such benefit and the benefit to which he would be entitled if his primary insurance amount were determined under such section without regard to such paragraph.

(6) For purposes of paragraph (1)(A), the "applicable percentage" is—

(A) 1/12 of 1 percent in the case of an individual who first becomes eligible for an old-age insurance benefit in any calendar year before 1979;

(B) 1/4 of 1 percent in the case of an individual who first becomes eligible for an old-age insurance benefit in any calendar year after 1978 and before 1987;

(C) in the case of an individual who first becomes eligible for an old-age insurance benefit in a calendar year after 1986 and before 2005, a percentage equal to the applicable percentage in effect under this paragraph for persons who first became eligible for an old-age insurance benefit in the preceding calendar year (as increased pursuant to this subparagraph), plus 1/24 of 1 percent if the calendar year in which that particular individual first becomes eligible for such benefit is not evenly divisible by 2; and

(D) 2/3 of 1 percent in the case of an individual who first becomes eligible for an old-age insurance benefit in a calendar year after 2004.

Limitation on Payments to Prisoners

(x)(1) Notwithstanding any other provision of this title, no monthly benefits shall be paid under this section or under section 223 to any individual for any month during which such individual is confined in a jail, prison, or other penal institution or correctional facility, pursuant to his conviction of an offense which constituted a felony under applicable law, unless such individual is actively and satisfactorily participating in a rehabilitation program which has been specifically approved for such individual by a court of law and, as determined by the Secretary, is expected to result in such individual being able to engage in substantial gainful activity upon release and within a reasonable time.

(2) Benefits which would be payable to any individual (other than a confined individual to whom benefits are not payable by reason of paragraph (1)) under this title on the basis of the wages and self-employment income of such a confined individual but for the provisions of paragraph (1), shall be payable as though such confined individual were receiving such benefits under this section or section 223.

(3) Notwithstanding the provisions of section 552a of title 5, United States Code, or any other provision of Federal or State law, any agency of the United States Government or of any State (or political subdivision thereof) shall make available to the Secretary, upon written request, the name and social security account number of any individual who is confined in a jail, prison, or other penal institution or correctional facility under the jurisdiction of such agency, pursuant to his conviction of an offense which constituted a felony under applicable law, which the Secretary may require to carry out the provisions of this subsection.

REDUCTION OF INSURANCE BENEFITS

Maximum Benefits

SEC. 203. [42 U.S.C. 403] (a)(1) In the case of an individual whose primary insurance amount has been computed or recomputed under section 215(a)(1) or (4), or section 215(d), as in effect after December 1978, the total monthly benefits to which beneficiaries may be entitled under section 202 or 223 for a month on the basis of the wages and self-employment income of such individual shall, except as provided by paragraphs (3) and (6) (but prior to any increases resulting from the application of paragraph (2)(A)(ii)(III) of section 215(i)), be reduced as necessary so as not to exceed—

(A) 150 percent of such individual's primary insurance amount to the extent that it does not exceed the amount established with respect to this subparagraph by paragraph (2),

(B) 272 percent of such individual's primary insurance amount to the extent that it exceeds the amount established with respect to subparagraph (A) but does not exceed the amount established with respect to this subparagraph by paragraph (2),

(C) 134 percent of such individual's primary insurance amount to the extent that it exceeds the amount established with respect to subparagraph (B) but does not exceed the amount established with respect to this subparagraph by paragraph (2), and

(D) 175 percent of such individual's primary insurance amount to the extent that it exceeds the amount established with respect to subparagraph (C).

Any such amount that is not a multiple of $0.10 shall be decreased to the next lower multiple of $0.10.

(2)(A) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming so eligible for such benefits), in the calendar year 1979, the amounts established with respect to subparagraphs (A), (B), and (C) of paragraph (1) shall be $230, $332, and $433, respectively.

(B) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming so eligible for such benefits), in any calendar year after 1979, each of the amounts so established shall equal the product of the corresponding amount established for the calendar year 1979 by subparagraph (A) of this paragraph and the quotient obtained under subparagraph (B)(ii) of section 215(a)(1), with such product being rounded in the manner prescribed by section 215(a)(1)(B)(iii).

(C) In each calendar year after 1978 the Secretary shall publish in the Federal Register, on or before November 1, the formula which (except as provided in section 215(i)(2)(D)) is to be applicable under this paragraph to individuals who become eligible for old-age or disability insurance benefits, or who die (before becoming eligible for such benefits), in the following calendar year.

(D) A year shall not be counted as the year of an individual's death or eligibility for purposes of this paragraph or paragraph (8) in any case where such individual was entitled to a disability insurance benefit for any of the 12 months immediately preceding the month of such death or eligibility (but there shall be counted instead the year of the individual's eligibility for the disability insurance benefits to which he was entitled during such 12 months).

(3)(A) When an individual who is entitled to benefits on the basis of the wages and self-employment income of any insured individual and to whom this subsection applies would (but for the provisions of section 202(k)(2)(A)) be entitled to child's insurance benefits for a month on the basis of the wages and self-employment income of one or more other insured individuals, the total monthly benefits to which all beneficiaries are entitled on the basis of such wages and self-employment income shall not be reduced under this subsection to less than the smaller of—

(i) the sum of the maximum amounts of benefits payable on the basis of the wages and self-employment income of all such insured individuals, or

(ii) an amount (I) initially equal to the product of 1.75 and the primary insurance amount that would be computed under section 215(a)(1), for January of the year determined for purposes of this clause under the following two sentences, with respect to average indexed monthly earnings equal to one-twelfth of the contribution and benefit base determined for that year under section 230, and (II) thereafter increased in accordance with the provisions of section 215(i)(2)(A)(ii).

The year established for purposes of clause (ii) shall be 1983 or, if it occurs later with respect to any individual, the year in which occurred the month that the application of the reduction provisions contained in this subparagraph began with respect to benefits payable on the basis of the wages and self-employment income of the insured individual. If for any month subsequent to the first month for which clause (ii) applies (with respect to benefits payable on the basis of the wages and self-employment income of the insured individual) the reduction under this subparagraph ceases to apply, then the year determined under the preceding sentence shall be redetermined (for purposes of any subsequent application of this subparagraph with respect to benefits payable on the basis of such wages and self-employment income) as though this subparagraph had not been previously applicable.

(B) When two or more persons were entitled (without the application of section 202(j)(1) and section 223(b)) to monthly benefits under section 202 or 223 for January 1971 or any prior month on the basis of the wages and self-employment income of such insured individual and the provisions of this subsection as in effect for any such month were applicable in determining the benefit amount of any persons on the basis of such wages and self-employment income, the total of benefits for any month after January 1971 shall not be reduced to less than the largest of—

(i) the amount determined under this subsection without regard to this subparagraph,

(ii) the largest amount which has been determined for any month under this subsection for persons entitled to monthly benefits on the basis of such insured individual's wages and self-employment income, or

(iii) if any persons are entitled to benefits on the basis of such wages and self-employment income for the month before the effective month (after September 1972) of a general benefit increase under this title (as defined in section 215(i)(3)) or a benefit increase under the provisions of section 215(i), an amount equal to the sum of amounts derived by multiplying the benefit amount determined under this title (excluding any part thereof determined under section 202(w)) for the month before such effective month (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section), for each such person for such month, by a percentage equal to the percentage of the increase provided under such benefit increase (with any such increased amount which is not a multiple of $0.10 being rounded to the next lower multiple of $0.10);

but in any such case (I) subparagraph (A) of this paragraph shall not be applied to such total of benefits after the application of clause (ii) or (iii), and (II) if section 202(k)(2)(A) was applicable in the case of any such benefits for a month, and ceases to apply for a month after such month, the provisions of clause (ii) or (iii) shall be applied, for and after the month in which section 202(k)(2)(A) ceases to apply, as though subparagraph (A) of this paragraph had not been applicable to such total of benefits for the last month for which clause (ii) or (iii) was applicable.

(C) When any of such individuals is entitled to monthly benefits as a divorced spouse under section 202(b) or (c) or as a surviving divorced spouse under section 202(e) or (f) for any month, the benefit to which he or she is entitled on the basis of the wages and self-employment income of such insured individual for such month shall be determined without regard to this subsection, and the benefits of all other individuals who are entitled for such month to monthly benefits under section 202 on the wages and self-employment income of such insured individual shall be determined as if no such divorced spouse or surviving divorced spouse were entitled to benefits for such month.

(D) In any case in which—

(i) two or more individuals are entitled to monthly benefits for the same month as a spouse under subsection (b) or (c) of section 202, or as a surviving spouse under subsection (e), (f), or (g) of section 202,

(ii) at least one of such individuals is entitled by reason of subparagraph (A)(ii) or (B) of section 216(h)(1), and

(iii) such entitlements are based on the wages and self-employment income of the same insured individual,

the benefit of the entitled individual whose entitlement is based on a valid marriage (as determined without regard to subparagraphs (A)(ii) and (B) of section 216(h)(1)) to such insured individual shall, for such month and all months thereafter, be determined without regard to this subsection, and the benefits of all other individuals who are entitled, for such month or any month thereafter, to monthly benefits under section 202 based on the wages and self-employment income of such insured individual shall be determined as if such entitled individual were not entitled to benefits for such month.[95]

(4) In any case in which benefits are reduced pursuant to the provisions of this subsection, the reduction shall be made after any deductions under this section and after any deductions under section 222(b). Whenever a reduction is made under this subsection in the total of monthly benefits to which individuals are entitled for any month on the basis of the wages and self-employment income of an insured individual, each such benefit other than the old-age or disability insurance benefit shall be proportionately decreased.

(5) Notwithstanding any other provision of law, when—

(A) two or more persons are entitled to monthly benefits for a particular month on the basis of the wages and self-employment income of an insured individual and (for such particular month) the provisions of this subsection are applicable to such monthly benefits, and

(B) such individual's primary insurance amount is increased for the following month under any provision of this title,

then the total of monthly benefits for all persons on the basis of such wages and self-employment income for such particular month, as determined under the provisions of this subsection, shall for purposes of determining the total monthly benefits for all persons on the basis of such wages and self-employment income for months subsequent to such particular month be considered to have been increased by the smallest amount that would have been required in order to assure that the total of monthly benefits payable on the basis of such wages and self-employment income for any such subsequent month will not be less (after the application of the other provisions of this subsection and section 202(q)) than the total of monthly benefits (after the application of the other provisions of this subsection and section 202(q)) payable on the basis of such wages and self-employment income for such particular month.

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[95] P.L. 101-508, §5119(c), added subparagraph (D), applicable to benefits for months after December 1990. See Vol. II, P.L. 101-508, §5119(e)(2), with respect to application requirement.

(6) Notwithstanding any of the preceding provisions of this subsection other than paragraphs (3)(A), (3)(C), (3)(D),[96] (4), and (5) (but subject to section 215(i)(2)(A)(ii)), the total monthly benefits to which beneficiaries may be entitled under sections 202 and 223 for any month on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits shall be reduced (before the application of section 224) to the smaller of—

(A) 85 percent of such individual's average indexed monthly earnings (or 100 percent of his primary insurance amount, if larger), or

(B) 150 percent of such individual's primary insurance amount.

(7) In the case of any individual who is entitled for any month to benefits based upon the primary insurance amounts of two or more insured individuals, one or more of which primary insurance amounts were determined under section 215(a) or 215(d) as in effect (without regard to the table contained therein) prior to January 1979 and one or more of which primary insurance amounts were determined under section 215(a)(1) or (4), or section 215(d), as in effect after December 1978, the total benefits payable to that individual and all other individuals entitled to benefits for that month based upon those primary insurance amounts shall be reduced to an amount equal to the amount determined in accordance with the provisions of paragraph (3)(A)(ii) of this subsection, except that for this purpose the references to subparagraph (A) in the last two sentences of paragraph (3)(A) shall be deemed to be references to paragraph (7).

(8) Subject to paragraph (7), this subsection as in effect in December 1978 shall remain in effect with respect to a primary insurance amount computed under section 215(a) or (d), as in effect (without regard to the table contained therein) in December 1978 and as amended by section 5117 of the Omnibus Budget Reconciliation Act of 1990,[97] except that a primary insurance amount so computed with respect to an individual who first becomes eligible for an old-age or disability insurance benefit, or dies (before becoming eligible for such a benefit), after December 1978, shall instead be governed by this section as in effect after December 1978. For purposes of the preceding sentence, the phrase "rounded to the next higher multiple of $0.10", as it appeared in subsection (a)(2)(C) of this section as in

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[96] P.L. 101-508, §5119(d), inserted "(3)(D),", applicable to benefits for months after December 1990. See Vol. II, P.L. 101-508, §5119(e)(2), with respect to application requirement.

[97] P.L. 101-508, §5117(a)(3)(B), inserted "and as amended by section 5117 of the Omnibus Budget Reconciliation Act of 1990".

See Vol. II, P.L. 101-508, 5117(a)(4), with respect to the effective date.

effect in December 1978, shall be deemed to read "rounded to the next lower multiple of $0.10".

(9) When—

(A) one or more persons were entitled (without the application of section 202(j)(1)) to monthly benefits under section 202 for May 1978 on the basis of the wages and self-employment income of an individual,

(B) the benefit of at least one such person for June 1978 is increased by reason of the amendments made by section 204 of the Social Security Amendments of 1977[98]; and

(C) the total amount of benefits to which all such persons are entitled under such section 202 are reduced under the provisions of this subsection (or would be so reduced except for the first sentence of section 203(a)(4)),

then the amount of the benefit to which each such person is entitled for months after May 1978 shall be increased (after such reductions are made under this subsection) to the amount such benefits would have been if the benefit of the person or persons referred to in subparagraph (B) had not been so increased.

Deductions on Account of Work

(b)(1) Deductions, in such amounts and at such time or times as the Secretary shall determine, shall be made from any payment or payments under this title to which an individual is entitled, and from any payment or payments to which any other persons are entitled on the basis of such individual's wages and self-employment income, until the total of such deductions equals—

(A) such individual's benefit or benefits under section 202 for any month, and

(B) if such individual was entitled to old-age insurance benefits under section 202(a) for such month, the benefit or benefits of all other persons for such month under section 202 based on such individual's wages and self-employment income,

if for such month he is charged with excess earnings, under the provisions of subsection (f) of this section, equal to the total of benefits referred to in clauses (A) and (B). If the excess earnings so charged are less than such total of benefits, such deductions with respect to such month shall be equal only to the amount of such excess earnings. If a child who has attained the age of 18 and is entitled to child's insurance benefits, or a person who is entitled to mother's or father's insurance benefits, is married to an individual entitled to old-age insurance benefits under section 202(a), such child or such person, as the case may be, shall, for the purposes of this subsection and subsection (f), be deemed to be entitled to such benefits on the basis of the wages and self-employment income of such individual entitled to old-age insurance benefits. If a deduction has already been made under this subsection with respect to a person's benefit or benefits under section 202 for a month, he shall be deemed entitled to payments under such section for such month for purposes of further deductions under this subsection, and for purposes of charging of each person's excess earnings under subsection (f), only to the extent of the total of his benefits remaining after such earlier deductions have been made. For purposes of this subsection and subsection (f)—

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[98] P.L. 95-216.

(i) an individual shall be deemed to be entitled to payments under section 202 equal to the amount of the benefit or benefits to which he is entitled under such section after the application of subsection (a) of this section, but without the application of the first sentence of paragraph (4) thereof; and

(ii) if a deduction is made with respect to an individual's benefit or benefits under section 202 because of the occurrence in any month of an event specified in subsection (c) or (d) of this section or in section 222(b), such individual shall not be considered to be entitled to any benefits under such section 202 for such month.

(2)(A) Except as provided in subparagraph (B), in any case in which—

(i) any of the other persons referred to in paragraph (1)(B) is entitled to monthly benefits as a divorced spouse under section 202(b) or (c) for any month, and

(ii) such person has been divorced for not less than 2 years,

the benefit[99] to which he or she is entitled on the basis of the wages and self-employment income of the individual referred to in paragraph (1) for such month shall be determined without regard to deductions under this subsection as a result of excess earnings of such individual, and the benefits of all other individuals who are entitled for such month to monthly benefits under section 202 on the basis of the wages and self-employment income of such individual referred to in paragraph (1) shall be determined as if no such divorced spouse were entitled to benefits for such month.

(B) Clause (ii) of subparagraph (A) shall not apply with respect to any divorced spouse in any case in which the individual referred to in paragraph (1) became entitled to old-age insurance benefits under section 202(a) before the date of the divorce.[100]

Deductions on Account of Noncovered Work Outside the United States or Failure to Have Child in Care

(c)Deductions, in such amounts and at such time or times as the Secretary shall determine, shall be made from any payment or payments under this title to which an individual is entitled, until the total of such deductions equals such individual's benefits or benefit under section 202 for any month—

(1) in which such individual is under the age of seventy and for more than forty-five hours of which such individual engaged in noncovered remunerative activity outside the United States;

(2) in which such individual, if a wife or husband under retirement age (as defined in section 216(l)) entitled to a wife's or

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[99] P.L. 101-508, §5127(a)(1), struck out "(2) When any of the other persons referred to in paragraph (1)(B) is entitled to monthly benefits as a divorced spouse under section 202(b) or (c) for any month and such person has been so divorced for not less than 2 years, the benefit", and substituted "(2)(A) Except as provided in subparagraph (B), in any case in which—
(i) any of the other persons referred to in paragraph (1)(B) is entitled to monthly
benefits as a divorced spouse under section 202(b) or (c) for any month, and
(ii) such person has been divorced for not less than 2 years,
the benefit", applicable to benefits for months after December 1990.

[100] P.L. 101-508, §5127(a)(2), added subparagraph (B), applicable to benefits for months after December 1990.

husband's insurance benefit, did not have in his or her care (individually or jointly with his or her spouse) a child of such spouse entitled to a child's insurance benefit and such wife's or husband's insurance benefit for such month was not reduced under the provisions of section 202(q);

(3) in which such individual, if a widow or widower entitled to a mother's or father's insurance benefit, did not have in his or her care a child of his or her deceased spouse entitled to a child's insurance benefit; or

(4) in which such an individual, if a surviving divorced mother or father entitled to a mother's or father's insurance benefit, did not have in his or her care a child of his or her deceased former spouse who (A) is his or her son, daughter, or legally adopted child and (B) is entitled to a child's insurance benefit on the basis of the wages and self-employment income of such deceased former spouse.

For purposes of paragraphs (2), (3), and (4) of this subsection, a child shall not be considered to be entitled to a child's insurance benefit for any month in which paragraph (1) of section 202(s) applies or an event specified in section 222(b) occurs with respect to such child. Subject to paragraph (3) of such section 202(s), no deduction shall be made under this subsection from any child's insurance benefit for the month in which the child entitled to such benefit attained the age of eighteen or any subsequent month; nor shall any deduction be made under this subsection from any widow's insurance benefit for any month in which the widow or surviving divorced wife is entitled and has not attained retirement age (as defined in section 216(l)) (but only if she became so entitled prior to attaining age 60), or from any widower's insurance benefit for any month in which the widower or surviving divorced husband is entitled and has not attained retirement age (as defined in section 216(l)) (but only if he became so entitled prior to attaining age 60).

Deductions From Dependents' Benefits on Account of Noncovered Work Outside the United States by Old-Age Insurance Beneficiary

(d)(1)(A) Deductions shall be made from any wife's, husband's, or child's insurance benefit, based on the wages and self-employment income of an individual entitled to old-age insurance benefits, to which a wife, divorced wife, husband, divorced husband, or child is entitled, until the total of such deductions equals such wife's, husband's, or child's insurance benefit or benefits under section 202 for any month in which such individual is under the age of seventy and for more than forty-five hours of which such individual engaged in noncovered remunerative activity outside the United States.

(B)(i) Except as provided in clause (ii), in any case in which—

(I) a divorced spouse is entitled to monthly benefits under section 202(b) or (c) for any month, and

(II) such divorced spouse has been divorced for not less than 2 years,

the benefit[101] to which he or she is entitled for such month on the basis of the wages and self-employment income of the individual entitled to old-age insurance benefits referred to in subparagraph (A) shall be determined without regard to deductions under this paragraph as a result of excess earnings of such individual, and the benefits of all other individuals who are entitled for such month to monthly benefits under section 202 on the basis of the wages and self-employment income of such individual referred to in subparagraph (A) shall be determined as if no such divorced spouse were entitled to benefits for such month.

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[101] P.L. 101-508, §5127(b)(1), struck out "(B) When any divorced spouse is entitled to monthly benefits under section 202(b) or (c) for any month and such divorced spouse has been so divorced for not less than 2 years, the benefit", and substituted

"(B)(i) Except as provided in clause (ii), in any case in which—

(ii) Subclause (II) of clause (i) shall not apply with respect to any divorced spouse in any case in which the individual entitled to old-age insurance benefits referred to in subparagraph (A) became entitled to such benefits before the date of the divorce.[102]

(2) Deductions shall be made from any child's insurance benefit to which a child who has attained the age of eighteen is entitled, or from any mother's or father's insurance benefit to which a person is entitled, until the total of such deductions equals such child's insurance benefit or benefits or mother's or father's insurance benefit or benefits under section 202 for any month in which such child or person entitled to mother's or father's insurance benefits is married to an individual under the age of seventy who is entitled to old-age insurance benefits and for more than forty-five hours of which such individual engaged in noncovered remunerative activity outside the United States.

Occurrence of More Than One Event

(e) If more than one of the events specified in subsections (c) and (d) and section 222(b) occurs in any one month which would occasion deductions equal to a benefit for such month, only an amount equal to such benefit shall be deducted.

Months to Which Earnings Are Charged

(f) For purposes of subsection (b)—

(1) The amount of an individual's excess earnings (as defined in paragraph (3)) shall be charged to months as follows: There shall be charged to the first month of such taxable year an amount of his excess earnings equal to the sum of the payments to which he and all other persons (excluding divorced spouses referred to in subsection (b)(2)) are entitled for such month under section 202 on the basis of his wages and self-employment income (or the total of his excess earnings if such excess earnings are less than such sum), and the balance, if any, of such excess earnings shall be charged to each succeeding month in such year to the extent, in the case of each such month, of the sum of the payments to which such individual and all such other persons are entitled for such month under section 202 on the basis of his wages and self-employment income, until the total of such excess has been so charged. Where an individual is entitled to benefits

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(I) a divorced spouse is entitled to monthly benefits under section 202(b) or (c) for any month, and

(II) such divorced spouse has been divorced for not less than 2 years,

the benefit", applicable to benefits for months after December 1990.

[102] P.L. 101-508, §5127(b)(2), added clause (ii), applicable to benefits for months after December 1990.

under section 202(a) and other persons (excluding divorced spouses referred to in subsection (b)(2)) are entitled to benefits under section 202(b), (c), or (d) on the basis of the wages and self-employment income of such individual, the excess earnings of such individual for any taxable year shall be charged in accordance with the provisions of this subsection before the excess earnings of such persons for a taxable year are charged to months in such individual's taxable year. Notwithstanding the preceding provisions of this paragraph but subject to section 202(s), no part of the excess earnings of an individual shall be charged to any month (A) for which such individual was not entitled to a benefit under this title, (B) in which such individual was age seventy or over, (C) in which such individual, if a child entitled to child's insurance benefits, has attained the age of 18, (D) for which such individual is entitled to widow's insurance benefits and has not attained retirement age (as defined in section 216(l)) (but only if she became so entitled prior to attaining age 60), or widower's insurance benefits and has not attained retirement age (as defined in section 216(l)) (but only if he became so entitled prior to attaining age 60), (E) in which such individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5) of this subsection) of more than the applicable exempt amount as determined under paragraph (8), if such month is in the taxable year in which occurs the first month after December 1977 that is both (i) a month for which the individual is entitled to benefits under subsection (a), (b), (c), (d), (e), (f), (g), or (h) of section 202 (without having been entitled for the preceding month to a benefit under any other of such subsections), and (ii) a month in which the individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5)) of more than the applicable exempt amount as determined under paragraph (8), or (F) in which such individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5) of this subsection) of more than the applicable exempt amount as determined under paragraph (8), in the case of an individual entitled to benefits under section 202(b) or (c) (but only by reason of having a child in his or her care within the meaning of paragraph (1)(B) of subsection (b) or (c), as may be applicable) or under section 202(d) or (g), if such month is in a year in which such entitlement ends for a reason other than the death of such individual, and such individual is not entitled to any benefits under this title for the month following the month during which such entitlement under section 202(b), (d), or (g) ended.

(2) As used in paragraph (1), the term "first month of such taxable year" means the earliest month in such year to which the charging of excess earnings described in such paragraph is not prohibited by the application of clauses (A), (B), (C), (D), (E), and (F) thereof.

(3) For purposes of paragraph (1) and subsection (h), an individual's excess earnings for a taxable year shall be 33 1/3

percent[103] of his earnings for such year in excess of the product of the applicable exempt amount as determined under paragraph (8) in the case of an individual who has attained (or, but for the individual's death, would have attained) retirement age (as defined in section 216(l)) before the close of such taxable year, or 50 percent of his earnings for such year in excess of such product in the case of any other individual[104], multiplied by the number of months in such year, except that, in determining an individual's excess earnings for the taxable year in which he attains age 70, there shall be excluded any earnings of such individual for the month in which he attains such age and any subsequent month (with any net earnings or net loss from self-employment in such year being prorated in an equitable manner under regulations of the Secretary). For purposes of the preceding sentence, notwithstanding section 211(e), the number of months in the taxable year in which an individual dies shall be 12. The excess earnings as derived under the first sentence of this paragraph, if not a multiple of $1, shall be reduced to the next lower multiple of $1.

(4) For purposes of clause (E) of paragraph (1)—

(A) An individual will be presumed, with respect to any month, to have been engaged in self-employment in such month until it is shown to the satisfaction of the Secretary that such individual rendered no substantial services in such month with respect to any trade or business the net income or loss of which is includible in computing (as provided in paragraph (5) of this subsection) his net earnings or net loss from self-employment for any taxable year. The Secretary shall by regulations prescribe the methods and criteria for determining whether or not an individual has rendered substantial services with respect to any trade or business.

(B) An individual will be presumed, with respect to any month, to have rendered services for wages (determined as provided in paragraph (5) of this subsection) of more than the applicable exempt amount as determined under paragraph (8) until it is shown to the satisfaction of the Secretary that such individual did not render such services in such month for more than such amount.

(5)(A) An individual's earnings for a taxable year shall be (i) the sum of his wages for services rendered in such year and his net earnings from self-employment for such year, minus (ii) any net loss from self-employment for such year.

(B) For purposes of this section—

(i) an individual's net earnings from self-employment for any taxable year shall be determined as provided in section 211, except that paragraphs (1), (4), and (5) of section 211(c) shall not apply and the gross income shall be computed by excluding the amounts provided by subparagraph (D), and

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[103] P.L. 98-21, §347(a), struck out "50 per centum" and substituted "33 1/3 percent", effective only with respect to taxable years beginning after December 1989, and only in the case of individuals who have attained retirement age (as defined in §216(l) of the Act).

[104] P.L. 98-21, §347(a), inserted "in the case of an individual who has attained retirement age (as defined in section 216(l)) before the close of such taxable year, or 50 percent of his earnings for such year in excess of such product in the case of any other individual", effective only with respect to taxable years beginning after December 1989, and only in the case of individuals who have attained retirement age (as defined in §216(l) of the Act).

(ii) an individual's net loss from self-employment for any taxable year is the excess of the deductions (plus his distributive share of loss described in section 702(a)(8) of the Internal Revenue Code of 1954[105]) taken into account under clause (i) over the gross income (plus his distributive share of income so described) taken into account under clause (i).

(C) For purposes of this subsection, an individual's wages shall be computed without regard to the limitations as to amounts of remuneration specified in paragraphs (1), (6)(B), (6)(C), (7)(B), and (8) of section 209(a)[106]; and in making such computation services which do not constitute employment as defined in section 210, performed within the United States by the individual as an employee or performed outside the United States in the active military or naval service of the United States, shall be deemed to be employment as so defined if the remuneration for such services is not includible in computing his net earnings or net loss from self-employment. The term "wages" does not include—

(i) the amount of any payment made to, or on behalf of, an employee or any of his dependents (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) on account of retirement, or[107]

(ii) any payment or series of payments by an employer to an employee or any of his dependents upon or after the termination of the employee's employment relationship because of retirement after attaining an age specified in a plan referred to in section 209(a)(11)(B)[108] or in a pension plan of the employer.[109]

(D) In the case of—

(i) an individual who has attained retirement age (as defined in section 216(l)) on or before the last day of the taxable year, and who shows to the satisfaction of the Secretary that he or she is receiving royalties attributable to a copyright or patent obtained before the taxable year in which he or she attained such age and that the property to which the copyright or patent relates was created by his or her own personal efforts, or

(ii) an individual who has become entitled to insurance benefits under this title, other than benefits under section 223 or benefits payable under section 202(d) by reason of being under a disability, and who shows to the satisfaction of the Secretary that he or she is receiving, in a year after his or her initial year of entitlement to such benefits, any other income not attributable to services performed after the month in which he or she initially became entitled to such benefits,

there shall be excluded from gross income any such royalties or other income.

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[105] P.L. 83-591.

[106] P.L. 101-239, §10208(d)(2)(A)(ii), struck out "subsections (a), (g)(2), (g)(3), (h)(2), and (j) of section 209" and substituted "paragraphs (1), (6)(B), (6)(C), (7)(B), and (8) of section 209(a)", effective December 19, 1989.

[107] Alignment as in original.

[108] P.L. 101-239, §10208(d)(2)(A)(vi), struck out "209(m)(2)" and substituted "209(a)(11)(B)", effective December 19, 1989.

[109] Alignment as in original.

(E) For purposes of this section, any individual's net earnings from self-employment which result from or are attributable to[110] the performance of services by such individual as a director of a corporation during any taxable year shall be deemed to have been derived (and received) by such individual in that year, at the time the services were performed, regardless of when the income, on which the computation of such net earnings from self-employment is based, is actually paid[111] to or received by such individual (unless such income was[112] actually paid and received prior to that year).[113]

(6) For purposes of this subsection, wages (determined as provided in paragraph (5)(C)) which, according to reports received by the Secretary, are paid to an individual during a taxable year shall be presumed to have been paid to him for services performed in such year until it is shown to the satisfaction of the Secretary that they were paid for services performed in another taxable year. If such reports with respect to an individual show his wages for a calendar year, such individual's taxable year shall be presumed to be a calendar year for purposes of this subsection until it is shown to the satisfaction of the Secretary that his taxable year is not a calendar year.

(7) Where an individual's excess earnings are charged to a month and the excess earnings so charged are less than the total of the payments (without regard to such charging) to which all persons (excluding divorced spouses referred to in subsection (b)(2)) are entitled under section 202 for such month on the basis of his wages and self-employment income, the difference between such total and the excess so charged to such month shall be paid (if it is otherwise payable under this title) to such individual and other persons in the proportion that the benefit to which each of them is entitled (without regard to such charging, without the application of section 202(k)(3), and prior to the application of section 203(a)) bears to the total of the benefits to which all of them are entitled.

(8)(A) Whenever the Secretary pursuant to section 215(i) increases benefits effective with the month of December following a cost-of-living computation quarter he shall also determine and publish in the Federal Register on or before November 1 of the calendar year in which such quarter occurs the new exempt amounts (separately stated for individuals described in subparagraph (D) and for other individuals) which are to be applicable (unless prevented from becoming effective by subparagraph (C)) with respect to taxable years ending in (or with the close of) the calendar year after the calendar year in which such benefit increase is effective (or, in the case of an individual who dies during the calendar year after the calendar year in which the benefit increase is effective, with respect to such individual's taxable year which ends, upon his death, during such year).

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[110] P.L. 101-508, §5123(a)(2)(A), struck out "Any income of an individual which results from or is attributable to" and substituted "(E) For purposes of this section, any individual's net earnings from self-employment which result from or are attributable to", applicable to income received for services performed in taxable years beginning after December 31, 1990.

[111] P.L. 101-508, §5123(a)(2)(B), struck out "the income is actually paid", and substituted "the income, on which the computation of such net earnings from self-employment is based, is actually paid", applicable to income received for services performed in taxable years beginning after December 31, 1990.

[112] P.L. 101-508, §5123(a)(2)(C), struck out "unless it was" and substituted "unless such income was", applicable to income received for services performed in taxable years beginning after Decemer 31, 1990.

[113] P.L. 101-508, §5123(a)(1), moved the last undesignated paragraph of §211(a) to this location.

(B) Except as otherwise provided in subparagraph (D), the exempt amount which is applicable to individuals described in such subparagraph and the exempt amount which is applicable to other individuals, for each month of a particular taxable year, shall each be whichever of the following is the larger—

(i) the corresponding exempt amount which is in effect with respect to months in the taxable year in which the determination under subparagraph (A) is made, or

(ii) the product of the exempt amount described in clause (i) and the ratio of (I) the deemed average total wages (as defined in section 209(k)(1))[114] for the calendar year before the calendar year in which the determination under subparagraph (A) is made to (II) the deemed average total wages (as so defined)[115] for the calendar year before the most recent calendar year in which an increase in the exempt amount was enacted or a determination resulting in such an increase was made under subparagraph (A), with such product, if not a multiple of $10, being rounded to the next higher multiple of $10 where such product is a multiple of $5 but not of $10 and to the nearest multiple of $10 in any other case.[116]

Whenever the Secretary determines that an exempt amount is to be increased in any year under this paragraph, he shall notify the House Committee on Ways and Means and the Senate Committee on Finance within 30 days after the close of the base quarter (as defined in section 215(i)(1)(A)) in such year of the estimated amount of such increase, indicating the new exempt amount, the actuarial estimates of the effect of the increase, and the actuarial assumptions and methodology used in preparing such estimates.

(C) Notwithstanding the determination of a new exempt amount by the Secretary under subparagraph (A) (and notwithstanding any publication thereof under such subparagraph or any notification thereof under the last sentence of subparagraph (B)), such new exempt amount shall not take effect pursuant thereto if during the calendar year in which such determination is made a law increasing the exempt amount is enacted.

(D) Notwithstanding any other provision of this subsection, the exempt amount which is applicable to an individual who has attained retirement age (as defined in section 216(l)) before the close of the taxable year involved—

(i) shall be $333.33 1/3 for each month of any taxable year ending after 1977 and before 1979,

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[114] P.L. 101-239, §10208(b)(1)(A), struck out "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1)[*]) reported to the Secretary of the Treasury or his delegate" and substituted "the deemed average total wages (as defined in section 209(k)(1))", applicable to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

[*] P.L. 101-239, §10208(d)(2)(A)(i), struck out "209(a)" and substituted "209(a)(1)", effective December 19, 1989.

[115] P.L. 101-239, §10208(b)(1)(B), struck out "the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate" and substituted "the deemed average total wages (as so defined)", applicable to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

[116] Retirement test exempt amounts for persons under age 65 are: $570 a month and $6,840 for the year 1990 (54 FR 40801, October 31, 1989).

(ii) shall be $375 for each month of any taxable year ending after 1978 and before 1980,

(iii) shall be $416.66 2/3 for each month of any taxable year ending after 1979 and before 1981,

(iv) shall be $458.33 1/3 for each month of any taxable year ending after 1980 and before 1982, and

(v) shall be $500 for each month of any taxable year ending after 1981 and before 1983.[117]

(9) For purposes of paragraphs (3), (5)(D)(i), and (8)(D), the term "retirement age (as defined in section 216(l))", with respect to any individual entitled to monthly insurance benefits under section 202, means the retirement age (as so defined) which is applicable in the case of old-age insurance benefits, regardless of whether or not the particular benefits to which the individual is entitled (or the only such benefits) are old-age insurance benefits.

Penalty for Failure To Report Certain Events

(g) Any individual in receipt of benefits subject to deduction under subsection (c), (or who is in receipt of such benefits on behalf of another individual), because of the occurrence of an event specified therein, who fails to report such occurrence to the Secretary prior to the receipt and acceptance of an insurance benefit for the second month following the month in which such event occurred, shall suffer deductions in addition to those imposed under subsection (c) as follows:

(1) if such failure is the first one with respect to which an additional deduction is imposed by this subsection, such additional deduction shall be equal to his benefit or benefits for the first month of the period for which there is a failure to report even though such failure is with respect to more than one month;

(2) if such failure is the second one with respect to which an additional deduction is imposed by this subsection, such additional deduction shall be equal to two times his benefit or benefits for the first month of the period for which there is a failure to report even though such failure is with respect to more than two months; and

(3) if such failure is the third or a subsequent one for which an additional deduction is imposed under this subsection, such additional deduction shall be equal to three times his benefit or benefits for the first month of the period for which there is a failure to report even though the failure to report is with respect to more than three months;

except that the number of additional deductions required by this subsection shall not exceed the number of months in the period for which there is a failure to report. As used in this subsection, the term "period for which there is a failure to report" with respect to any individual means the period for which such individual received and accepted insurance benefits under section 202 without making a timely report and for which deductions are required under subsection (c).

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[117] 1990 $780, [$9,360] 54 FR 45801; October 31, 1989.

Report of Earnings to Secretary

(h)(1)(A) If an individual is entitled to any monthly insurance benefit under section 202 during any taxable year in which he has earnings or wages, as computed pursuant to paragraph (5) of subsection (f), in excess of the product of the applicable exempt amount as determined under subsection (f)(8) times the number of months in such year, such individual (or the individual who is in receipt of such benefit on his behalf) shall make a report to the Secretary of his earnings (or wages) for such taxable year. Such report shall be made on or before the fifteenth day of the fourth month following the close of such year, and shall contain such information and be made in such manner as the Secretary may by regulations prescribe. Such report need not be made for any taxable year (i) beginning with or after the month in which such individual attained age 70, or (ii) if benefit payments for all months (in such taxable year) in which such individual is under age 70 have been suspended under the provisions of the first sentence of paragraph (3) of this subsection. The Secretary may grant a reasonable extension of time for making the report of earnings required in this paragraph if he finds that there is valid reason for a delay, but in no case may the period be extended more than three months.

(B) If the benefit payments of an individual have been suspended for all months in any taxable year under the provisions of the first sentence of paragraph (3) of this subsection, no benefit payment shall be made to such individual for any such month in such taxable year after the expiration of the period of three years, three months, and fifteen days following the close of such taxable year unless within such period the individual, or some other person entitled to benefits under this title on the basis of the same wages and self-employment income, files with the Secretary information showing that a benefit for such month is payable to such individual.

(2) If an individual fails to make a report required under paragraph (1), within the time prescribed by or in accordance with such paragraph, for any taxable year and any deduction is imposed under subsection (b) by reason of his earnings for such year, he shall suffer additional deductions as follows:

(A) if such failure is the first one with respect to which an additional deduction is imposed under this paragraph, such additional deduction shall be equal to his benefit or benefits for the last month of such year for which he was entitled to a benefit under section 202, except that if the deduction imposed under subsection (b) by reason of his earnings for such year is less than the amount of his benefit (or benefits) for the last month of such year for which he was entitled to a benefit under section 202, the additional deduction shall be equal to the amount of the deduction imposed under subsection (b) but not less than $10;

(B) if such failure is the second one for which an additional deduction is imposed under this paragraph, such additional deduction shall be equal to two times his benefit or benefits for the last month of such year for which he was entitled to a benefit under section 202;

(C) if such failure is the third or a subsequent one for which an additional deduction is imposed under this paragraph, such additional deduction shall be equal to three times his benefit or benefits for the last month of such year for which he was entitled to a benefit under section 202;

except that the number of the additional deductions required by this paragraph with respect to a failure to report earnings for a taxable year shall not exceed the number of months in such year for which such individual received and accepted insurance benefits under section 202 and for which deductions are imposed under subsection (b) by reason of his earnings. In determining whether a failure to report earnings is the first or a subsequent failure for any individual, all taxable years ending prior to the imposition of the first additional deduction under this paragraph, other than the latest one of such years, shall be disregarded.

(3) If the Secretary determines, on the basis of information obtained by or submitted to him, that it may reasonably be expected that an individual entitled to benefits under section 202 for any taxable year will suffer deductions imposed under subsection (b) by reason of his earnings for such year, the Secretary may, before the close of such taxable year, suspend the total or less than the total payment for each month in such year (or for only such months as the Secretary may specify) of the benefits payable on the basis of such individual's wages and self-employment income; and such suspension shall remain in effect with respect to the benefits for any month until the Secretary has determined whether or not any deduction is imposed for such month under subsection (b). The Secretary is authorized, before the close of the taxable year of an individual entitled to benefits during such year, to request of such individual that he make, at such time or times as the Secretary may specify, a declaration of his estimated earnings for the taxable year and that he furnish to the Secretary such other information with respect to such earnings as the Secretary may specify. A failure by such individual to comply with any such request shall in itself constitute justification for a determination under this paragraph that it may reasonably be expected that the individual will suffer deductions imposed under subsection (b) by reason of his earnings for such year. If, after the close of a taxable year of an individual entitled to benefits under section 202 for such year, the Secretary requests such individual to furnish a report of his earnings (as computed pursuant to paragraph (5) of subsection (f)) for such taxable year or any other information with respect to such earnings which the Secretary may specify, and the individual fails to comply with such request, such failure shall in itself constitute justification for a determination that such individual's benefits are subject to deductions under subsection (b) for each month in such taxable year (or only for such months thereof as the Secretary may specify) by reason of his earnings for such year.

(4) The Secretary shall develop and implement procedures in accordance with this subsection to avoid paying more than the correct amount of benefits to any individual under this title as a result of such individual's failure to file a correct report or estimate of earnings or wages. Such procedures may include identifying categories of individuals who are likely to be paid more than the correct amount of benefits and requesting that they estimate their earnings or wages more frequently than other persons subject to deductions under this section on account of earnings or wages.

Circumstances Under Which Deductions Not Required

(i) In the case of any individual, deductions by reason of the provisions of subsection (b), (c), (g), or (h) of this section, or the provisions of section 222(b), shall, notwithstanding such provisions, be made from the benefits to which such individual is entitled only to the extent that such deductions reduce the total amount which would otherwise be paid, on the basis of the same wages and self-employment income, to such individual and the other individuals living in the same household.

Attainment of Age Seventy

(j) For the purposes of this section, an individual shall be considered as seventy years of age during the entire month in which he attains such age.

Noncovered Remunerative Activity Outside the United States

(k) An individual shall be considered to be engaged in noncovered remunerative activity outside the United States if he performs services outside the United States as an employee and such services do not constitute employment as defined in section 210 and are not performed in the active military or naval service of the United States, or if he carries on a trade or business outside the United States (other than the performance of service as an employee) the net income or loss of which (1) is not includible in computing his net earnings from self-employment for a taxable year and (2) would not be excluded from net earnings from self-employment, if carried on in the United States, by any of the numbered paragraphs of section 211(a). When used in the preceding sentence with respect to a trade or business (other than the performance of service as an employee), the term "United States" does not include the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa in the case of an alien who is not a resident of the United States (including the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa); and the term "trade or business" shall have the same meaning as when used in section 162 of the Internal Revenue Code of 1954[118].

Good Cause for Failure To Make Reports Required

(l) The failure of an individual to make any report required by subsection (g) or (h)(1)(A) within the time prescribed therein shall not be regarded as such a failure if it is shown to the satisfaction of the Secretary that he had good cause for failing to make such report within such time. The determination of what constitutes good cause for purposes of this subsection shall be made in accordance with regulations of the Secretary, except that in making any such determination, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language)[119].

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[118] P.L. 83-591.

[119] P.L. 101-239, §10305(a), inserted ", except that in making any such determination, the Secretary shall specifically take into account any physical, mental, educational, or linguistic

OVERPAYMENTS AND UNDERPAYMENTS[120]

SEC. 204. [42 U.S.C. 404] (a)(1) Whenever the Secretary finds that more or less than the correct amount of payment has been made to any person under this title, proper adjustment or recovery shall be made, under regulations prescribed by the Secretary, as follows:

(A) With respect to payment to a person of more than the correct amount, the Secretary shall decrease any payment under this title to which such overpaid person is entitled, or shall require such overpaid person or his estate to refund the amount in excess of the correct amount, or shall decrease any payment under this title payable to his estate or to any other person on the basis of the wages and self-employment income which were the basis of the payments to such overpaid person, or shall obtain recovery by means of reduction in tax refunds based on notice to the Secretary of the Treasury as permitted under section 3720A of title 31, United States Code,[121] or shall apply any combination of the foregoing. A payment made under this title on the basis of an erroneous report of death by the Department of Defense of an individual in the line of duty while he is a member of the uniformed services (as defined in section 210(m)) on active duty (as defined in section 210(l)) shall not be considered an incorrect payment for any month prior to the month such Department notifies the Secretary that such individual is alive.

(B) With respect to payment to a person of less than the correct amount, the Secretary shall make payment of the balance of the amount due such underpaid person, or, if such person dies before payments are completed or before negotiating one or more checks representing correct payments, disposition of the amount due shall be made in accordance with subsection (d).

(2) Notwithstanding any other provision of this section, when any payment of more than the correct amount is made to or on behalf of an individual who has died, and such payment—

(A) is made by direct deposit to a financial institution;

(B) is credited by the financial institution to a joint account of the deceased individual and another person; and

(C) such other person was entitled to a monthly benefit on the basis of the same wages and self-employment income as the deceased individual for the month preceding the month in which the deceased individual died,

the amount of such payment in excess of the correct amount shall be treated as a payment of more than the correct amount to such other person.

(b) In any case in which more than the correct amount of payment has been made, there shall be no adjustment of payments to, or recovery by the United States from, any person who is without fault

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limitation such individual may have (including any lack of facility with the English language)", applicable with respect to determinations made on or after July 1, 1990.

[120] See §1870 with respect to adjustment of Title XVIII overpayments against payment of benefits under Title II.

[121] P.L. 101-508, §5129(a), inserted "or shall obtain recovery by means of reduction in tax refunds based on notice to the Secretary of the Treasury as permitted under section 3720A of title 31, United States Code,", effective January 1, 1991, and shall not apply to refunds to which the amendments made by section 2653 of the Deficit Reduction Act of 1984 (98 Stat. 1153) do not apply.

if such adjustment or recovery would defeat the purpose of this title or would be against equity and good conscience. In making for purposes of this subsection any determination of whether any individual is without fault, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).[122]

(c) No certifying or disbursing officer shall be held liable for any amount certified or paid by him to any person where the adjustment or recovery of such amount is waived under subsection (b), or where adjustment under subsection (a) is not completed prior to the death of all persons against whose benefits deductions are authorized.

(d) If an individual dies before any payment due him under this title is completed, payment of the amount due (including the amount of any unnegotiated checks) shall be made—

(1) to the person, if any, who is determined by the Secretary to be the surviving spouse of the deceased individual and who either (i) was living in the same household with the deceased at the time of his death or (ii) was, for the month in which the deceased individual died, entitled to a monthly benefit on the basis of the same wages and self-employment income as was the deceased individual;

(2) if there is no person who meets the requirements of paragraph (1), or if the person who meets such requirements dies before the payment due him under this title is completed, to the child or children, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(3) if there is no person who meets the requirements of paragraph (1) or (2), or if each person who meets such requirements dies before the payment due him under this title is completed, to the parent or parents, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent);

(4) if there is no person who meets the requirements of paragraph (1), (2), or (3), or if each person who meets such requirements dies before the payment due him under this title is completed, to the person, if any, determined by the Secretary to be the surviving spouse of the deceased individual;

(5) if there is no person who meets the requirements of paragraph (1), (2), (3), or (4), or if each person who meets such requirements dies before the payment due him under this title is completed, to the person or persons, if any, determined by the Secretary to be the child or children of the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

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[122] P.L. 101-239, §10305(b), added this sentence, applicable with respect to determinations made on or after July 1, 1990.

(6) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), or (5), or if each person who meets such requirements dies before the payment due him under this title is completed, to the parent or parents, if any, of the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent); or

(7) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), or (6), or if each person who meets such requirements dies before the payment due him under this title is completed, to the legal representative of the estate of the deceased individual, if any.

(e) For payments which are adjusted by reason of payment of benefits under the supplemental security income program established by title XVI, see section 1127.

EVIDENCE, PROCEDURE, AND CERTIFICATION FOR PAYMENT[123]

SEC. 205. [42 U.S.C. 405] (a) The Secretary shall have full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this title, which are necessary or appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder.

(b)(1) The Secretary is directed to make findings of fact, and decisions as to the rights of any individual applying for a payment under this title. Any such decision by the Secretary which involves a determination of disability and which is in whole or in part unfavorable to such individual shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the Secretary's determination and the reason or reasons upon which it is based. Upon request by any such individual or upon request by a wife, divorced wife, widow, surviving divorced wife, surviving divorced mother, surviving divorced father, husband, divorced husband, widower, surviving divorced husband, child, or parent who makes a showing in writing that his or her rights may be prejudiced by any decision the Secretary has rendered, he shall give such applicant and such other individual reasonable notice and opportunity for a hearing with respect to such decision, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing, affirm, modify, or reverse his findings of fact and such decision. Any such request with respect to such a decision must be filed within sixty days after notice of such decision is received by the individual making such request. The Secretary is further authorized, on his own motion, to hold such hearings and to conduct such investigations and other proceedings as he may deem necessary or proper for the administration of this title. In the course of any hearing, investigation, or other proceeding, he may administer oaths and affirmations, examine witnesses, and receive evidence. Evidence may be received at any hearing before the Secretary even though inadmissible under rules of evidence applicable to court procedure.

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[123] See Vol. II, P.L. 84-885, §33, with respect to evidence of United States citizenship.
See Vol. II, P.L. 90-321, §913(2), with respect to electronic fund transfers.
See Vol. II, P.L. 94-437, §702, with respect to regulations applicable to Indians.
See Vol. II, P.L. 95-630, §§1101-1121, with respect to an individual's right to financial privacy.
See Vol. II, P.L. 97-455, §5, with respect to conduct of face-to-face reconsiderations in disability cases.

(2) In any case where—

(A) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurance benefits based on disability,

(B) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and

(C) as a consequence of the finding described in subparagraph (B), such individual is determined by the Secretary not to be entitled to such benefits,

any reconsideration of the finding described in subparagraph (B), in connection with a reconsideration by the Secretary (before any hearing under paragraph (1) on the issue of such entitlement) of his determination described in subparagraph (C), shall be made only after opportunity for an evidentiary hearing, with regard to the finding described in subparagraph (B), which is reasonably accessible to such individual. Any reconsideration of a finding described in subparagraph (B) may be made either by the State agency or the Secretary where the finding was originally made by the State agency, and shall be made by the Secretary where the finding was originally made by the Secretary. In the case of a reconsideration by a State agency of a finding described in subparagraph (B) which was originally made by such State agency, the evidentiary hearing shall be held by an adjudicatory unit of the State agency other than the unit that made the finding described in subparagraph (B). In the case of a reconsideration by the Secretary of a finding described in subparagraph (B) which was originally made by the Secretary, the evidentiary hearing shall be held by a person other than the person or persons who made the finding described in subparagraph (B).

(3)(A) A failure to timely request review of an initial adverse determination with respect to an application for any benefit under this title or an adverse determination on reconsideration of such an initial determination shall not serve as a basis for denial of a subsequent application for any benefit under this title if the applicant demonstrates that the applicant, or any other individual referred to in paragraph (1), failed to so request such a review acting in good faith reliance upon incorrect, incomplete, or misleading information, relating to the consequences of reapplying for benefits in lieu of seeking review of an adverse determination, provided by any officer or employee of the Social Security Administration or any State agency acting under section 221.

(B) In any notice of an adverse determination with respect to which a review may be requested under paragraph (1), the Secretary shall describe in clear and specific language the effect on possible entitlement to benefits under this title of choosing to reapply in lieu of requesting review of the determination.[124]

(c)(1) For the purposes of this subsection—

(A) The term "year" means a calendar year when used with respect to wages and a taxable year when used with respect to self-employment income.

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[124] P.L. 101-508, §5107(a)(1), added paragraph (3), applicable to adverse determinations made on or after July 1, 1991. Alinement as in original.

(B) The term "time limitation" means a period of three years, three months, and fifteen days.

(C) The term "survivor" means an individual's spouse, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father, child, or parent, who survives such individual.

(D) The term "period" when used with respect to self-employment income means a taxable year and when used with respect to wages means—

(i) a quarter if wages were reported or should have been reported on a quarterly basis on tax returns filed with the Secretary of the Treasury or his delegate under section 6011 of the Internal Revenue Code of 1954[125] or regulations thereunder (or on reports filed by a State under section 218(e) (as in effect prior to December 31, 1986) or regulations thereunder),

(ii) a year if wages were reported or should have been reported on a yearly basis on such tax returns or reports, or

(iii) the half year beginning January 1 or July 1 in the case of wages which were reported or should have been reported for calendar year 1937.

(2)(A) On the basis of information obtained by or submitted to the Secretary, and after such verification thereof as he deems necessary, the Secretary shall establish and maintain records of the amounts of wages paid to, and the amounts of self-employment income derived by, each individual and of the periods in which such wages were paid and such income was derived and, upon request, shall inform any individual or his survivor, or the legal representative of such individual or his estate, of the amounts of wages and self-employment income of such individual and the periods during which such wages were paid and such income was derived, as shown by such records at the time of such request.

(B)(i) In carrying out his duties under subparagraph (A) and subparagraph (E)[126], the Secretary shall take affirmative measures to assure that social security account numbers will, to the maximum extent practicable, be assigned to all members of appropriate groups or categories of individuals by assigning such numbers (or ascertaining that such numbers have already been assigned):

(I) to aliens at the time of their lawful admission to the United States either for permanent residence or under other authority of law permitting them to engage in employment in the United States and to other aliens at such time as their status is so changed as to make it lawful for them to engage in such employment;

(II) to any individual who is an applicant for or recipient of benefits under any program financed in whole or in part from Federal funds including any child on whose behalf such benefits are claimed by another person; and

(III) to any other individual when it appears that he could have been but was not assigned an account number under the provisions of subclauses (I) or (II) but only after such investigation as is necessary to establish to the satisfaction of the Secretary, the identity of such individual, the fact that an account number has not already been assigned to such individual, and the fact that such individual is a citizen or a noncitizen who is not, because of his alien status, prohibited from engaging in employment;

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[125] P.L. 83-591.

[126] P.L. 100-647, §8009(a)(1), inserted "and subparagraph (E)", applicable to benefits entitlement to which commences after May 1989.

and, in carrying out such duties, the Secretary is authorized to take affirmative measures to assure the issuance of social security numbers:

(IV) to or on behalf of children who are below school age at the request of their parents or guardians; and

(V) to children of school age at the time of their first enrollment in school.

(ii) The Secretary shall require of applicants for social security account numbers such evidence as may be necessary to establish the age, citizenship, or alien status, and true identity of such applicants, and to determine which (if any) social security account number has previously been assigned to such individual.

(iii) In carrying out the requirements of this subparagraph, the Secretary shall enter into such agreements as may be necessary with the Attorney General and other officials and with State and local welfare agencies and school authorities (including non-public[127] school authorities).

(C)(i)[128] It is the policy of the United States that any State (or political subdivision thereof) may, in the administration of any tax, general public assistance, driver's license, or motor vehicle registration law within its jurisdiction, utilize the social security account numbers issued by the Secretary for the purpose of establishing the identification of individuals affected by such law, and may require any individual who is or appears to be so affected to furnish to such State (or political subdivision thereof) or any agency thereof having administrative responsibility for the law involved, the social security account number (or numbers, if he has more than one such number) issued to him by the Secretary.

(ii)[129] In the administration of any law involving the issuance of a birth certificate, each State shall require each parent to furnish to such State (or political subdivision thereof) or any agency thereof having administrative responsibility for the law involved, the social security account number (or numbers, if the parent has more than one such number) issued to the parent unless the State (in accordance with regulations prescribed by the Secretary) finds good cause for not requiring the furnishing of such number. The State shall make numbers furnished under this subclause available to the agency administering the State's plan under part D of title IV in accordance with Federal or State law and regulation. Such numbers shall not be recorded on the birth certificate. A State shall not use any social security account number, obtained with respect to the issuance by the State of a birth certificate, for any purpose other than for the enforcement of child support orders in effect in the State, unless section 7(a) of the Privacy Act of 1974 does not prohibit the State from requiring the disclosure of such number, by reason of the State having adopted, before January 1, 1975, a statute or regulation requiring such disclosure.

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[127] As in original.

[128] P.L. 101-624, §1735(a)(2), redesignated subclause (I) as clause (i).

P.L. 101-624, §2201(b)(2), also redesignated subclause (I) as clause (i).

See Vol. II, P.L. 80-759, §12(e), with respect to disclosure of the social security number for individuals required to submit to registration.

See Vol. II, P.L. 83-591, §6109, with respect to use of a social security number as a "taxpayer identifying number" as that term is used in the "Debt Collection Act of 1982" [P.L. 97-365].

See Vol. II, P.L. 88-525, §16(e), with respect to use of the social security number for participation in the food stamp program.

[129] P.L. 100-485, §125(a)(1)(B), added subclause (II), effective November 1, 1990.

P.L. 101-624, §1735(a)(2), redesignated subclause (II) as clause (ii).

P.L. 101-624, §2201(b)(2), also redesignated subclause (II) as clause (ii).

(iii) In the administration of section 9 of the Food Stamp Act of 1977 (7 U.S.C. 2018) involving the determination of the qualifications of applicants under such Act, the Secretary of Agriculture may require each applicant retail store or wholesale food concern to furnish to the Secretary of Agriculture the social security account number of each individual who is an officer of the store or concern and, in the case of a privately owned applicant, furnish the social security account numbers of the owners of such applicant. No officer or employee of the Department of Agriculture shall have access to any such number for any purpose other than the establishment and maintenance of a list of the names and social security account numbers of such individuals for use in determining those applicants who have been previously sanctioned or convicted under section 12 or 15 of such Act (7 U.S.C. 2021 or 2024). The Secretary of Agriculture shall restrict, to the satisfaction of the Secretary of Health and Human Services, access to social security account numbers obtained pursuant to this clause only to officers and employees of the United States whose duties or responsibilities require access for the administration or enforcement of the Food Stamp Act of 1977. The Secretary of Agriculture shall provide such other safeguards as the Secretary of Health and Human Services determines to be necessary or appropriate to protect the confidentiality of the social security account numbers.[130]

(iii) In the administration of section 506 of the Federal Crop Insurance Act, the Federal Crop Insurance Corporation may require each policyholder and each reinsured company to furnish to the insurer or to the Corporation the social security account number of such policyholder, subject to the requirements of this clause. No officer or employee of the Federal Crop Insurance Corporation shall have access to any such number for any purpose other than the establishment of a system of records necessary for the effective administration of such Act. The Manager of the Corporation may require each policyholder to provide to the Manager, at such times and in such manner as prescribed by the Manager, the social security account number of each individual that holds or acquires a substantial beneficial interest in the policyholder. For purposes of this clause, the term "substantial beneficial interest" means not less than 5 percent of all beneficial interest in the policyholder. The Secretary of Agriculture shall restrict, to the satisfaction of the Secretary of Health and Human Services, access to social security account numbers obtained pursuant to this clause only to officers and employees of the United States or authorized persons whose duties or responsibilities require access for the administration of the Federal Crop Insurance Act. The Secretary of Agriculture shall provide such other safeguards as the Secretary of Health and Human Services determines to be necessary or appropriate to protect the confidentiality of such social security account numbers. For purposes of this clause the term "authorized person" means an officer or employee of an insurer whom the Manager of the Corporation designates by rule, subject to appropriate safeguards including a prohibition against the release of such social security account number (other than to the Corporation) by such person.[131]

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[130] P.L. 101-624, §1735(a)(3), added this clause (iii), effective November 28, 1990.

(iv)[132] If and to the extent that any provision of Federal law heretofore enacted is inconsistent with the policy set forth in subclause (I) of clause (i)[133], such provision shall, on and after the date of the enactment of this subparagraph[134], be null, void, and of no effect. If and to the extent that any such provision is inconsistent with the requirement set forth in subclause (II) of clause (i), such provision shall, on and after the date of the enactment of such subclause[135], be null, void, and of no effect.[136]

(v)[137] For purposes of clause (i) of this subparagraph, an agency of a State (or political subdivision thereof) charged with the administration of any general public assistance, driver's license, or motor vehicle registration law which did not use the social security account number for identification under a law or regulation adopted before January 1, 1975, may require an individual to disclose his or her social security number to such agency solely for the purpose of administering the laws referred to in clause (i) above and for the purpose of responding to requests for information from an agency operating pursuant to the provisions of part A or D of title IV of this Act.

(vi)[138] For purposes of this subparagraph, the term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Marianas, and the Trust Territory of the Pacific Islands.

(vii)(I) Social security account numbers and related records that are obtained or maintained by authorized persons pursuant to any provision of law enacted on or after October 1, 1990, shall be confidential, and no authorized person shall disclose any such social security account number or related record.

(II) Paragraphs (1), (2), and (3) of section 7213(a) of the Internal Revenue Code of 1986 shall apply with respect to the unauthorized willful disclosure to any person of social security account numbers and related records obtained or maintained by an authorized person pursuant to a provision of law enacted on or after October 1, 1990, in the same manner and to the same extent as such paragraphs apply with respect to unauthorized disclosures of return and return information described in such paragraphs. Paragraph (4) of section 7213(a) of such Code shall apply with respect to the willful offer of any item of material value in exchange for any such social security account number or related record in the same manner and to the same extent as such paragraph applies with respect to offers (in exchange for any return or return information) described in such paragraph.

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[131] P.L. 101-624, §2201(b)(3), added this clause (iii), effective November 28, 1990.

[132] P.L. 101-624, §1735(a)(1), redesignated clause (ii) as clause (iv).
P.L. 101-624, §2201(b)(1), also redesignated clause (ii) as clause (iv).

[133] P.L. 100-485, §125(a)(2)(A), struck out "clause (i) of this subparagraph" and substituted "subclause (I) of clause (i)", effective November 1, 1990.

[134] This subparagraph was enacted on October 4, 1976 [P.L. 94-455, §1211(b); 90 Stat. 1711].

[135] Subclause (II) of clause (i) was enacted in October 13, 1988. [P.L. 100-485; 102 Stat. 2353].

[136] P.L. 100-485, §125(a)(2)(B), added this sentence, effective November 1, 1990.

[137] P.L. 101-624, §1735(a)(1), redesignated clause (iii) as clause (v).
P.L. 101-624, §2201(b)(1), also redesignated clause (iii) as clause (v).

[138] P.L. 101-624, §1735(a)(1), redesignated clause (iv) as clause (vi).
P.L. 101-624, §2201(b)(1), also redesignated clause (iv) as clause (vi).

(III) For purposes of this clause, the term "authorized person" means an officer or employee of the United States, an officer or employee of any State, political subdivision of a State, or agency of a State or political subdivision of a State, and any other person (or officer or employee thereof), who has or had access to social security account numbers or related records pursuant to any provision of law enacted on or after October 1, 1990. For purposes of this subclause, the term "officer or employee" includes a former officer or employee.

(IV) For purposes of this clause, the term "related record" means any record, list, or compilation that indicates, directly or indirectly, the identity of any individual with respect to whom a request for a social security account number is maintained pursuant to this clause.[139]

(vii)(I) Social security account numbers and related records that are obtained or maintained by authorized persons pursuant to any provision of law, enacted on or after October 1, 1990, shall be confidential, and no authorized person shall disclose any such social security account number or related record.

(II) Paragraphs (1), (2), and (3) of section 7213(a) of the Internal Revenue Code of 1986 shall apply with respect to the unauthorized willful disclosure to any person of social security account numbers and related records obtained or maintained by an authorized person pursuant to a provision of law enacted on or after October 1, 1990, in the same manner and to the same extent as such paragraphs as such paragraphs[140] apply with respect to unauthorized disclosures of returns and return information described in such paragraphs. Paragraph (4) of such 7213(a) of such Code shall apply with respect to the willful offer of any item of material value in exchange for any such social security account number or related record in the same manner and to the same extent as such paragraph applies with respect to offers (in exchange for any return or return information) described in such paragraph.

(III) For purposes of this clause, the term "authorized person" means an officer or employee of the United States, an officer or employee of any State, political subdivision of a State, or agency of a State or political subdivision of a State, and any other person (or officer or employee thereof), who has or had access to social security account numbers or related records pursuant to any provision of law enacted on or after October 1, 1990. For purposes of this subclause, the term "officer or employee" includes a former officer or employee.

(IV) For purposes of this clause, the term "related record" means any record, list, or compilation that indicates, directly or indirectly, the identity of any individual with respect to whom a social security account number is maintained pursuant to this clause.[141]

(D)(i) It is the policy of the United States that—

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[139] P.L. 101-624, §1735(b), added this clause (vii), effective November 28, 1990.

[140] As in original. Second "as such paragraphs" probably should be deleted.

[141] P.L. 101-624, §2201(c), added this clause (vii), effective November 28, 1990. As in original. One clause (vii) probably should be deleted.

(I) any State (or any political subdivision of a State) and any authorized blood donation facility may utilize the social security account numbers issued by the Secretary for the purpose of identifying blood donors, and

(II) any State (or political subdivision of a State) may require any individual who donates blood within such State (or political subdivision) to furnish to such State (or political subdivision), to any agency thereof having related administrative responsibility, or to any authorized blood donation facility the social security account number (or numbers, if the donor has more than one such number) issued to the donor by the Secretary.

(ii) If and to the extent that any provision of Federal law enacted before the date of the enactment of this subparagraph[142] is inconsistent with the policy set forth in clause (i), such provision shall, on and after such date, be null, void, and of no effect.

(iii) For purposes of this subparagraph—

(I) the term "authorized blood donation facility" means an entity described in section 1141(h)(1)(B), and

(II) the term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Marianas, and the Trust Territory of the Pacific Islands.

(E) The Secretary shall require, as a condition for receipt of benefits under this title, that an individual furnish satisfactory proof of a social security account number assigned to such individual by the Secretary or, in the case of an individual to whom no such number has been assigned, that such individual make proper application for assignment of such a number.[143]

(F) The Secretary shall issue a social security card to each individual at the time of the issuance of a social security account number to such individual. The social security card shall be made of banknote paper, and (to the maximum extent practicable) shall be a card which cannot be counterfeited.[144]

(3) The Secretary's record shall be evidence for the purpose of proceedings before the Secretary or any court of the amounts of wages paid to, and self-employment income derived by, an individual and of the periods in which such wages were paid and such income was derived. The absence of an entry in such records as to wages alleged to have been paid to, or as to self-employment income alleged to have been derived by, an individual in any period shall be evidence that no such alleged wages were paid to, or that no such alleged income was derived by, such individual during such period.

(4) Prior to the expiration of the time limitation following any year the Secretary may, if it is brought to his attention that any entry of wages or self-employment income in his records for such year is erroneous or that any item of wages or self-employment income for such year has been omitted from such records, correct such entry or include such omitted item in his records, as the case may be. After the expiration of the time limitation following any year—

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[142] This subparagraph was enacted November 10, 1988.

[143] P.L. 100-647, §8009(a)(3), added this subparagraph (E), applicable to benefits entitlement to which commences after May 1989.

[144] See Vol. II, P.L. 101-166 and P.L. 101-517, with respect to social security cards.

(A) the Secretary's records (with changes, if any, made pursuant to paragraph (5)) of the amounts of wages paid to, and self-employment income derived by, an individual during any period in such year shall be conclusive for the purposes of this title;

(B) the absence of an entry in the Secretary's records as to the wages alleged to have been paid by an employer to an individual during any period in such year shall be presumptive evidence for the purposes of this title that no such alleged wages were paid to such individual in such period; and

(C) the absence of an entry in the Secretary's records as to the self-employment income alleged to have been derived by an individual in such year shall be conclusive for the purposes of this title that no such alleged self-employment income was derived by such individual in such year unless it is shown that he filed a tax return of his self-employment income for such year before the expiration of the time limitation following such year, in which case the Secretary shall include in his records the self-employment income of such individual for such year.

(5) After the expiration of the time limitation following any year in which wages were paid or alleged to have been paid to, or self-employment income was derived or alleged to have been derived by, an individual, the Secretary may change or delete any entry with respect to wages or self-employment income in his records of such year for such individual or include in his records of such year for such individual any omitted item of wages or self-employment income but only—

(A) if an application for monthly benefits or for a lump-sum death payment was filed within the time limitation following such year; except that no such change, deletion, or inclusion may be made pursuant to this subparagraph after a final decision upon the application for monthly benefits or lump-sum death payment;

(B) if within the time limitation following such year an individual or his survivor makes a request for a change or deletion, or for an inclusion of an omitted item, and alleges in writing that the Secretary's records of the wages paid to, or the self-employment income derived by, such individual in such year are in one or more respects erroneous; except that no such change, deletion, or inclusion may be made pursuant to this subparagraph after a final decision upon such request. Written notice of the Secretary's decision on any such request shall be given to the individual who made the request;

(C) to correct errors apparent on the face of such records;

(D) to transfer items to records of the Railroad Retirement Board if such items were credited under this title when they should have been credited under the Railroad Retirement Act of 1937 or 1974, or to enter items transferred by the Railroad Retirement Board which have been credited under the Railroad Retirement Act of 1937 or 1974 when they should have been credited under this title;

(E) to delete or reduce the amount of any entry which is erroneous as a result of fraud;

(F) to conform his records to—

(i) tax returns or portions thereof (including information returns and other written statements) filed with the Commissioner of Internal Revenue under title VIII of the Social Security Act, under subchapter E of chapter 1 or subchapter A of chapter 9 of the Internal Revenue Code of 1939[145], under chapter 2 or 21 of the Internal Revenue Code of 1954[146], or under regulations made under authority of such title, subchapter, or chapter;

(ii) wage reports filed by a State pursuant to an agreement under section 218 or regulations of the Secretary thereunder; or

(iii) assessments of amounts due under an agreement pursuant to section 218 (as in effect prior to December 31, 1986), if such assessments are made within the period specified in subsection (q) of such section (as so in effect), or allowances of credits or refunds of overpayments by a State under an agreement pursuant to such section;

except that no amount of self-employment income of an individual for any taxable year (if such return or statement was filed after the expiration of the time limitation following the taxable year) shall be included in the Secretary's records pursuant to this subparagraph;

(G) to correct errors made in the allocation, to individuals or periods, of wages or self-employment income entered in the records of the Secretary;

(H) to include wages paid during any period in such year to an individual by an employer[147];

(I) to enter items which constitute remuneration for employment under subsection (o), such entries to be in accordance with certified reports of records made by the Railroad Retirement Board pursuant to section 5(k)(3) of the Railroad Retirement Act of 1937 or section 7(b)(7) of the Railroad Retirement Act of 1974; or

(J) to include self-employment income for any taxable year, up to, but not in excess of, the amount of wages deleted by the Secretary as payments erroneously included in such records as wages paid to such individual, if such income (or net earnings from self-employment), not already included in such records as self-employment income, is included in a return or statement (referred to in subparagraph (F)) filed before the expiration of the time limitation following the taxable year in which such deletion of wages is made.

(6) Written notice of any deletion or reduction under paragraph (4) or (5) shall be given to the individual whose record is involved or to his survivor, except that (A) in the case of a deletion or reduction with respect to any entry of wages such notice shall be given to such individual only if he has previously been notified by the Secretary of the amount of his wages for the period involved, and (B) such notice shall be given to such survivor only if he or the individual whose record is involved has previously been notified by the Secretary of

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[145] P.L. 76-1.

[146] See P.L. 83-591, chapter 2 (this volume).

[147] P.L. 101-239, §10304, struck out "if there is an absence of an entry in the Secretary's records of wages having been paid by such employer to such individual in such period", effective December 19, 1989.

the amount of such individual's wages and self-employment income for the period involved.

(7) Upon request in writing (within such period, after any change or refusal of a request for a change of his records pursuant to this subsection, as the Secretary may prescribe), opportunity for hearing with respect to such change or refusal shall be afforded to any individual or his survivor. If a hearing is held pursuant to this paragraph the Secretary shall make findings of fact and a decision based upon the evidence adduced at such hearing and shall include any omitted items, or change or delete any entry, in his records as may be required by such findings and decision.

(8) Decisions of the Secretary under this subsection shall be reviewable by commencing a civil action in the United States district court as provided in subsection (g).

(d) For the purpose of any hearing, investigation, or other proceeding authorized or directed under this title, or relative to any other matter within his jurisdiction hereunder, the Secretary shall have power to issue subpenas requiring the attendance and testimony of witnesses and the production of any evidence that relates to any matter under investigation or in question before the Secretary. Such attendance of witnesses and production of evidence at the designated place of such hearing, investigation, or other proceeding may be required from any place in the United States or in any Territory or possession thereof. Subpenas of the Secretary shall be served by anyone authorized by him (1) by delivering a copy thereof to the individual named therein, or (2) by registered mail or by certified mail addressed to such individual at his last dwelling place or principal place of business. A verified return by the individual so serving the subpena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post-office receipt therefor signed by the individual so served, shall be proof of service. Witnesses so subpenaed shall be paid the same fees and mileage as are paid witnesses in the district courts of the United States.

(e) In case of contumacy by, or refusal to obey a subpena duly served upon, any person, any district court of the United States for the judicial district in which said person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Secretary, shall have jurisdiction to issue an order requiring such person to appear and give testimony, or to appear and produce evidence, or both; any failure to obey such order of the court may be punished by said court as contempt thereof.

[(f) Repealed.[148]]

(g) Any individual, after any final decision of the Secretary made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the

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[148] P.L. 91-452, §236; 84 Stat. 930.

United States District Court for the District of Columbia. As part of his answer the Secretary shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, with or without remanding the cause for a rehearing. The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Secretary or a decision is rendered under subsection (b) hereof which is adverse to an individual who was a party to the hearing before the Secretary, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) hereof, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court may, on motion of the Secretary made for good cause shown before he files his answer, remand the case to the Secretary for further action by the Secretary, and it may at any time order additional evidence to be taken before the Secretary, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding; and the Secretary shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm his findings of fact or his decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and a transcript of the additional record and testimony upon which his action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Secretary or any vacancy in such office.

(h) The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28, United States Code, to recover on any claim arising under this title.

(i) Upon final decision of the Secretary, or upon final judgment of any court of competent jurisdiction that any person is entitled to any payment or payments under this title, the Secretary shall certify to the Managing Trustee the name and address of the person so entitled to receive such payment or payments, the amount of such payment or payments, and the time at which such payment or payments should be made, and the Managing Trustee, through the Fiscal Service of the Department of the Treasury[149], and prior to any action thereon by the General Accounting Office, shall make payment in accordance with the certification of the Secretary (except that in the case of (A) an individual who will have completed ten years of service creditable under the Railroad Retirement Act of 1937 or the Railroad Retirement Act of 1974[150], (B) the wife or husband of such an individual, (C) any survivor of such an individual if such survivor is entitled, or could upon application become entitled, to an annuity under section 2 of the Railroad Retirement Act of 1974, and (D) any other person entitled to benefits under section 202 of this Act on the basis of the wages and self-employment income of such an individual (except a survivor of such an individual where such individual did not have a current connection with the railroad industry, as defined in the Railroad Retirement Act of 1974, at the time of his death), such certification shall be made to the Railroad Retirement Board which shall provide for such payment or payments to such person on behalf of the Managing Trustee in accordance with the provisions of the Railroad Retirement Act of 1974): *Provided*, That where a review of the Secretary's decision is or may be sought under subsection (g) the Secretary may withhold certification of payment pending such review. The Managing Trustee shall not be held personally liable for any payment or payments made in accordance with a certification by the Secretary.

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[149] See Vol. II, P.L. 98-473, §1212, with respect to the requirement that the Secretary of the Treasury provide for certain printed notices regarding the commission of forgery in conjunction with the cashing or attempted cashing of checks issued for benefits under Title II.

REPRESENTATIVE PAYEES[151]

(j)(1) If the Secretary determines that the interest of any individual under this title would be served thereby, certification of payment of such individual's benefit under this title may be made, regardless of the legal competency or incompetency of the individual, either for direct payment to the individual, or for his or her use and benefit, to another individual, or an organization, with respect to whom the requirements of paragraph (2) have been met (hereinafter in this subsection referred to as the individual's "representative payee"). If the Secretary or a court of competent jurisdiction determines that a representative payee has misused any individual's benefit paid to such representative payee pursuant to this subsection or section 1631(a)(2), the Secretary shall promptly revoke certification for payment of benefits to such representative payee pursuant to this subsection and certify payment to an alternative representative payee or to the individual.[152]

(2)(A) Any certification made under paragraph (1) for payment of benefits to an individual's representative payee shall be made on the basis of—

(i) an investigation by the Secretary of the person to serve as representative payee, which shall be conducted in advance of such certification and shall, to the extent practicable, include a face-to-face interview with such person, and

(ii) adequate evidence that such certification is in the interest of such individual (as determined by the Secretary in regulations).

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[150] P.L. 75-162 [as amended by P.L. 93-445].

[151] P.L. 101-508, §5105(a)(1)(A), added this heading.

See Vol. II, P.L. 101-508, §5105(b)(2), with respect to a study and report to be made to the Secretary.

[152] P.L. 101-508, §5105(a)(1)(A), amended paragraph (j)(1) in its entirety, effective July 1, 1991, applicable to certifications of payment of benefits under title II to representative payees made on or after such date.

(B)(i) As part of the investigation referred to in subparagraph (A)(i), the Secretary shall—

(I) require the person being investigated to submit documented proof of the identity of such person, unless information establishing such identity has been submitted with an application for benefits under this title or title XVI,

(II) verify such person's social security account number (or employer identification number),

(III) determine whether such person has been convicted of a violation of section 208 or 1632, and

(IV) determine whether certification of payment of benefits to such person has been revoked pursuant to this subsection or payment of benefits to such person has been terminated pursuant to section 1631(a)(2)(A)(iii) by reason of misuse of funds paid as benefits under this title or title XVI.

(ii) The Secretary shall establish and maintain a centralized file, which shall be updated periodically and which shall be in a form which renders it readily retrievable by each servicing office of the Social Security Administration. Such file shall consist of—

(I) a list of the names and social security account numbers (or employer identification numbers) of all persons with respect to whom certification of payment of benefits has been revoked on or after January 1, 1991, pursuant to this subsection, or with respect to whom payment of benefits has been terminated on or after such date pursuant to section 1631(a)(2)(A)(iii), by reason of misuse of funds paid as benefits under this title or title XVI, and

(II) a list of the names and social security account numbers (or employer identification numbers) of all persons who have been convicted of a violation of section 208 or 1632.

(C)(i) Benefits of an individual may not be certified for payment to any other person pursuant to this subsection if—

(I) such person has previously been convicted as described in subparagraph (B)(i)(III),

(II) except as provided in clause (ii), certification of payment of benefits to such person under this subsection has previously been revoked as described in subparagraph (B)(i)(IV), or payment of benefits to such person pursuant to section 1631(a)(2)(A)(ii) has previously been terminated as described in section 1631(a)(2)(B)(ii)(IV), or

(III) except as provided in clause (iii), such person is a creditor of such individual who provides such individual with goods or services for consideration.

(ii) The Secretary shall prescribe regulations under which the Secretary may grant exemptions to any person from the provisions of clause (i)(II) on a case-by-case basis if such exemption is in the best interest of the individual whose benefits would be paid to such person pursuant to this subsection.

(iii) Clause (i)(III) shall not apply with respect to any person who is a creditor referred to therein if such creditor is—

(I) a relative of such individual if such relative resides in the same household as such individual,

(II) a legal guardian or legal representative of such individual,

(III) a facility that is licensed or certified as a care facility under the law of a State or a political subdivision of a State,

(IV) a person who is an administrator, owner, or employee of a facility referred to in subclause (III) if such individual resides in such facility, and the certification of payment to such facility or such person is made only after good faith efforts have been made by the local servicing office of the Social Security Administration to locate an alternative representative payee to whom such certification of payment would serve the best interests of such individual, or

(V) an individual who is determined by the Secretary, on the basis of written findings and under procedures which the Secretary shall prescribe by regulation, to be acceptable to serve as a representative payee.

(iv) The procedures referred to in clause (iii)(V) shall require the individual who will serve as representative payee to establish, to the satisfaction of the Secretary, that—

(I) such individual poses no risk to the beneficiary,

(II) the financial relationship of such individual to the beneficiary poses no substantial conflict of interest, and

(III) no other more suitable representative payee can be found.

(D)(i) Subject to clause (ii), if the Secretary makes a determination described in the first sentence of paragraph (1) with respect to any individual's benefit and determines that direct payment of the benefit to the individual would cause substantial harm to the individual, the Secretary may defer (in the case of initial entitlement) or suspend (in the case of existing entitlement) direct payment of such benefit to the individual, until such time as the selection of a representative payee is made pursuant to this subsection.

(ii)(I) Except as provided in subclause (II), any deferral or suspension of direct payment of a benefit pursuant to clause (i) shall be for a period of not more than 1 month.

(II) Subclause (I) shall not apply in any case in which the individual is, as of the date of the Secretary's determination, legally incompetent or under the age of 15.

(iii) Payment pursuant to this subsection of any benefits which are deferred or suspended pending the selection of a representative payee shall be made to the individual or the representative payee as a single sum or over such period of time as the Secretary determines is in the best interest of the individual entitled to such benefits.

(E)(i) Any individual who is dissatisfied with a determination by the Secretary to certify payment of such individual's benefit to a representative payee under paragraph (1) or with the designation of a particular person to serve as representative payee shall be entitled to a hearing by the Secretary to the same extent as is provided in subsection (b), and to judicial review of the Secretary's final decision as is provided in subsection (g).

(ii) In advance of the certification of payment of an individual's benefit to a representative payee under paragraph (1), the Secretary shall provide written notice of the Secretary's initial determination to certify such payment. Such notice shall be provided to such individual, except that, if such individual—

(I) is under the age of 15,

(II) is an unemancipated minor under the age of 18, or

(III) is legally incompetent,

then such notice shall be provided solely to the legal guardian or legal representative of such individual.

(iii) Any notice described in clause (ii) shall be clearly written in language that is easily understandable to the reader, shall identify the person to be designated as such individual's representative payee, and shall explain to the reader the right under clause (i) of such individual or of such individual's legal guardian or legal representative—

(I) to appeal a determination that a representative payee is necessary for such individual,

(II) to appeal the designation of a particular person to serve as the representative payee of such individual, and

(III) to review the evidence upon which such designation is based and submit additional evidence.[153]

(3)(A) In any case where payment under this title is made to a person other than the individual entitled to such payment, the Secretary shall establish a system of accountability monitoring whereby such person shall report not less often than annually with respect to the use of such payments. The Secretary shall establish and implement statistically valid procedures for reviewing such reports in order to identify instances in which such persons are not properly using such payments.

(B)[154] Subparagraph (A) shall not apply in any case where the other person to whom such payment is made is a State institution. In such cases, the Secretary shall establish a system of accountability monitoring for institutions in each State.

(C)[155] Subparagraph (A) shall not apply in any case where the individual entitled to such payment is a resident of a Federal institution and the other person to whom such payment is made is the institution.

(D)[156] Notwithstanding subparagraphs (A), (B), and (C)[157], the Secretary may require a report at any time from any person receiving payments on behalf of another, if the Secretary has reason to believe that the person receiving such payments is misusing such payments.

(E) The Secretary shall maintain a centralized file, which shall be updated periodically and which shall be in a form which will be readily retrievable by each servicing office of the Social Security Administration, of—

(i) the address and the social security account number (or employer identification number) of each representative payee who is receiving benefit payments pursuant to this subsection or section 1631(a)(2), and

(ii) the address and social security account number of each individual for whom each representative payee is reported to be providing services as representative payee pursuant to this subsection or section 1631(a)(2).[158]

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[153] P.L. 101-508, §5105(a)(2)(A)(i), amended paragraph (2) in its entirety, effective July 1, 1991, applicable to certifications of payment of benefits under title II to representative payees made on or after such date.

See Vol. II, P.L. 101-508, §5105(a)(2)(B), with respect to a study and report on the feasiblity of obtaining ready access to certain criminal fraud records.

[154] P.L. 101-508, §5105(b)(1)(A)(i) and (ii), struck out subparagraph (B), and redesignated subparagraph (C) as subparagraph (B), effective October 1, 1992. [For subparagraph (B) as it formerly read, see Vol. III, P.L. 101-508.]

[155] P.L. 101-508, §5105(b)(1)(A)(ii), redesignated subparagraph (D) as subparagraph (C), effective October 1, 1992.

[156] P.L. 101-508, §5105(b)(1)(A)(ii), redesignated subparagraph (E) as subparagraph (D), effective October 1, 1992.

[157] P.L. 101-508, §5105)(b)(1)(A)(iii), struck out "(A), (B), (C), and (D)" and substituted "(A), (B), and (C)", effective October 1, 1992.

(F) Each servicing office of the Administration shall maintain a list, which shall be updated periodically, of public agencies and community-based nonprofit social service agencies which are qualified to serve as representative payees pursuant to this subsection or section 1631(a)(2) and which are located in the area served by such servicing office.[159]

(4)(A) A qualified organization may collect from an individual a monthly fee for expenses (including overhead) incurred by such organization in providing services performed as such individual's representative payee pursuant to this subsection if such fee does not exceed the lesser of—

(i) 10 percent of the monthly benefit involved, or

(ii) $25.00 per month.

Any agreement providing for a fee in excess of the amount permitted under this subparagraph shall be void and shall be treated as misuse by such organization of such individual's benefits.

(B) For purposes of this paragraph, the term "qualified organization" means any community-based nonprofit social service agency which is bonded or licensed in each State in which it serves as a representative payee and which, in accordance with any applicable regulations of the Secretary—

(i) regularly provides services as the representative payee, pursuant to this subsection or section 1631(a)(2), concurrently to 5 or more individuals,

(ii) demonstrates to the satisfaction of the Secretary that such agency is not otherwise a creditor of any such individual, and

(iii) was in existence on October 1, 1988.

The Secretary shall prescribe regulations under which the Secretary may grant an exception from clause (ii) for any individual on a case-by-case basis if such exception is in the best interests of such individual.

(C) Any qualified organization which knowingly charges or collects, directly or indirectly, any fee in excess of the maximum fee prescribed under subparagraph (A) or makes any agreement, directly or indirectly, to charge or collect any fee in excess of such maximum fee, shall be fined in accordance with title 18, United States Code, or imprisoned not more than 6 months, or both.

(D) This paragraph shall cease to be effective on July 1, 1994.[160]

(5) In cases where the negligent failure of the Secretary to investigate or monitor a representative payee results in misuse of benefits by the representative payee, the Secretary shall certify for payment to the beneficiary or the beneficiary's alternative representative payee an amount equal to such misused benefits. The Secretary shall make a good faith effort to obtain restitution from the terminated representative payee.[161]

(6) The Secretary shall include as a part of the annual report required under section 704 information with respect to the imple-

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[158] P.L. 101-508, §5105(b)(1)(A)(iv), added subparagraph (E), effective October 1, 1992, and the Secretary shall take such actions as are necessary to ensure that the requirements of this subparagraph are satisfied as of such date.

[159] P.L. 101-508, §5105(b)(1)(A)(iv), added subparagraph (F), effective October 1, 1992.

[160] P.L. 101-508, §5105(a)(3)(A)(i), added a new paragraph (4), effective July 1, 1991, and the Secretary shall prescribe initial regulations necessary to carry out this amendment not later than such date.

[161] P.L. 101-508, §5105(c)(1), added this paragraph (5), effective November 5, 1990.

mentation of the preceding provisions of this subsection, including the number of cases in which the representative payee was changed, the number of cases discovered where there has been a misuse of funds, how any such cases were dealt with by the Secretary, the final disposition of such cases, including any criminal penalties imposed, and such other information as the Secretary determines to be appropriate.[162]

(k) Any payment made after December 31, 1939, under conditions set forth in subsection (j), any payment made before January 1, 1940, to, or on behalf of, a legally incompetent individual, and any payment made after December 31, 1939, to a legally incompetent individual without knowledge by the Secretary of incompetency prior to certification of payment, if otherwise valid under this title, shall be a complete settlement and satisfaction of any claim, right, or interest in and to such payment.

(l) The Secretary is authorized to delegate to any member, officer, or employee of the Department of Health and Human Services designated by him any of the powers conferred upon him by this section, and is authorized to be represented by his own attorneys in any court in any case or proceeding arising under the provisions of subsection (e).

[(m) Repealed.[163]]

(n) The Secretary may, in his discretion, certify to the Managing Trustee any two or more individuals of the same family for joint payment of the total benefits payable to such individuals for any month, and if one of such individuals dies before a check representing such joint payment is negotiated, payment of the amount of such unnegotiated check to the surviving individual or individuals may be authorized in accordance with regulations of the Secretary of the Treasury; except that appropriate adjustment or recovery shall be made under section 204(a) with respect to so much of the amount of such check as exceeds the amount to which such surviving individual or individuals are entitled under this title for such month.

Crediting of Compensation Under the Railroad Retirement Act

(o) If there is no person who would be entitled, upon application therefor, to an annuity under section 2 of the Railroad Retirement Act of 1974[164], or to a lump-sum payment under section 6(b) of such Act, with respect to the death of an employee (as defined in such Act), then, notwithstanding section 210(a)(9)[165] of this Act, compensation (as defined in such Railroad Retirement Act, but excluding compensation attributable as having been paid during any month on account of military service creditable under section 3(i) of such Act if wages are deemed to have been paid to such employee during such month under subsection (a) or (e) of section 217 of this Act) of such employee shall constitute remuneration for employment for purposes of determining (A) entitlement to and the amount of any lump-sum death payment under this title on the basis of such employee's wages and self-employment income and (B) entitlement to and the amount of any monthly benefit under this title, for the month in which such employee died or for any month thereafter, on the basis of such wages and self-employment income. For such purposes, compensation (as so defined) paid in a calendar year before 1978 shall, in the absence of evidence to the contrary, be presumed to have been paid in equal proportions with respect to all months in the year in which the employee rendered services for such compensation.

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[162] P.L. 101-508, §5105(a)(3)(A)(i), redesignated paragraph (4) as paragraph (5), effective July 1, 1991, and the Secretary was required to prescribe initial regulations necessary to carry out this amendment not later than such date.

P.L. 101-508, §5105(c)(1), redesignated that paragraph as paragraph (6).

P.L. 101-508, §5105(d)(1)(A), amended paragraph (5), [as so redesignated by subsection (a)(3)(A)(i) of P.L. 101-508, §5105], in its entirety, applicable to annual reports issued for years after 1991. [For that paragraph as it reads until then, see Vol. III, P.L. 101-508.]

See Vol. II, P.L. 101-508, §5105(a)(3)(B)(i) and (a)(4), with respect to studies and reports regarding organizations which serve as representative payees and the feasibility of screening individuals with criminal records; and §5105(b)(2), with respect to a study and report to be made by the Secretary.

[163] P.L. 81-734, §101(b)(2); 64 Stat. 488. See, instead, §202(j)(2).

[164] P.L. 75-162 [as amended by P.L. 93-445].

[165] P.L. 83-761, §101(a)(5), redesignated §210(a)(9) as §210(a)(10).

Special Rules in Case of Federal Service

(p)(1) With respect to service included as employment under section 210 which is performed in the employ of the United States or in the employ of any instrumentality which is wholly owned by the United States, including service, performed as a member of a uniformed service, to which the provisions of subsection (l)(1) of such section are applicable, and including service, performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act[166], to which the provisions of section 210(o) are applicable, the Secretary shall not make determinations as to the amounts of remuneration for such service, or the periods in which or for which such remuneration was paid, but shall accept the determinations with respect thereto of the head of the appropriate Federal agency or instrumentality, and of such agents as such head may designate, as evidenced by returns filed in accordance with the provisions of section 3122 of the Internal Revenue Code of 1954[167] and certifications made pursuant to this subsection. Such determinations shall be final and conclusive. Nothing in this paragraph shall be construed to affect the Secretary's authority to determine under sections 209 and 210 whether any such service constitutes employment, the periods of such employment, and whether remuneration paid for any such service constitutes wages.

(2) The head of any such agency or instrumentality is authorized and directed, upon written request of the Secretary, to make certification to him with respect to any matter determinable for the Secretary by such head or his agents under this subsection, which the Secretary finds necessary in administering this title.

(3) The provisions of paragraphs (1) and (2) shall be applicable in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense, at installations of the Department of Defense for the comfort, pleasure, contentment, and mental and physical improvement of personnel of such Department; and for purposes of paragraphs (1) and (2) the Secretary of Defense

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[166] P.L. 87-293.

[167] P.L. 83-591.

shall be deemed to be the head of such instrumentality. The provisions of paragraphs (1) and (2) shall be applicable also in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Transportation, at installations of the Coast Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard; and for purposes of paragraphs (1) and (2) the Secretary of Transportation shall be deemed to be the head of such instrumentality.

Expedited Benefit Payments

(q)(1) The Secretary shall establish and put into effect procedures under which expedited payment of monthly insurance benefits under this title will, subject to paragraph (4) of this subsection, be made as set forth in paragraphs (2) and (3) of this subsection.

(2) In any case in which—

(A) an individual makes an allegation that a monthly benefit under this title was due him in a particular month but was not paid to him, and

(B) such individual submits a written request for the payment of such benefit—

(i) in the case of an individual who received a regular monthly benefit in the month preceding the month with respect to which such allegation is made, not less than 30 days after the 15th day of the month with respect to which such allegation is made (and in the event that such request is submitted prior to the expiration of such 30-day period, it shall be deemed to have been submitted upon the expiration of such period), and

(ii) in any other case, not less than 90 days after the later of (I) the date on which such benefit is alleged to have been due, or (II) the date on which such individual furnished the last information requested by the Secretary (and such written request will be deemed to be filed on the day on which it was filed, or the ninetieth day after the first day on which the Secretary has evidence that such allegation is true, whichever is later),

the Secretary shall, if he finds that benefits are due, certify such benefits for payment, and payment shall be made within 15 days immediately following the date on which the written request is deemed to have been filed.

(3) In any case in which the Secretary determines that there is evidence, although additional evidence might be required for a final decision, that an allegation described in paragraph (2)(A) is true, he may make a preliminary certification of such benefit for payment even though the 30-day or 90-day periods described in paragraph (2)(B)(i) and (B)(ii) have not elapsed.

(4) Any payment made pursuant to a certification under paragraph (3) of this subsection shall not be considered an incorrect payment for purposes of determining the liability of the certifying or disbursing officer.

(5) For purposes of this subsection, benefits payable under section 228 shall be treated as monthly insurance benefits payable under this title. However, this subsection shall not apply with respect to any benefit for which a check has been negotiated, or with respect to any benefit alleged to be due under either section 223, or section 202 to a wife, husband, or child of an individual entitled to or applying for benefits under section 223, or to a child who has attained age 18 and is under a disability, or to a widow or widower on the basis of being under a disability.

Use of Death Certificates to Correct Program Information

(r)(1) The Secretary shall undertake to establish a program under which—

(A) States (or political subdivisions thereof) voluntarily contract with the Secretary to furnish the Secretary periodically with information (in a form established by the Secretary in consultation with the States) concerning individuals with respect to whom death certificates (or equivalent documents maintained by the States or subdivisions) have been officially filed with them; and

(B) there will be (i) a comparison of such information on such individuals with information on such individuals in the records being used in the administration of this Act, (ii) validation of the results of such comparisons, and (iii) corrections in such records to accurately reflect the status of such individuals.

(2) Each State (or political subdivision thereof) which furnishes the Secretary with information on records of deaths in the State or subdivision under this subsection may be paid by the Secretary from amounts available for administration of this Act the reasonable costs (established by the Secretary in consultations with the States) for transcribing and transmitting such information to the Secretary.

(3) In the case of individuals with respect to whom federally funded benefits are provided by (or through) a Federal or State agency other than under this Act, the Secretary shall to the extent feasible provide such information through a cooperative arrangement with such agency, for ensuring proper payment of those benefits with respect to such individuals if—

(A) under such arrangement the agency provides reimbursement to the Secretary for the reasonable cost of carrying out such arrangement, and

(B) such arrangement does not conflict with the duties of the Secretary under paragraph (1).

(4) The Secretary may enter into similar agreements with States to provide information for their use in programs wholly funded by the States if the requirements of subparagraphs (A) and (B) of paragraph (3) are met.

(5) The Secretary may use or provide for the use of such records as may be corrected under this section, subject to such safeguards as the Secretary determines are necessary or appropriate to protect the information from unauthorized use or disclosure, for statistical and research activities conducted by Federal and State agencies.

(6) Information furnished to the Secretary under this subsection may not be used for any purpose other than the purpose described in

this subsection and is exempt from disclosure under section 552 of title 5, United States Code, and from the requirements of section 552a of such title.

(7) The Secretary shall include information on the status of the program established under this section and impediments to the effective implementation of the program in the 1984 report required under section 704 of this Act.

NOTICE REQUIREMENTS[168]

(s) The Secretary shall take such actions as are necessary to ensure that any notice to one or more individuals issued pursuant to this title by the Secretary or by a State agency—

(1) is written in simple and clear language, and

(2) includes the address and telephone number of the local office of the Social Security Administration which serves the recipient.

In the case of any such notice which is not generated by a local servicing office, the requirements of paragraph (2) shall be treated as satisfied if such notice includes the address of the local office of the Social Security Administration which services the recipient of the notice and a telephone number through which such office can be reached.

Same-Day Personal Interviews at Field Offices In Cases Where Time Is of The Essence

(t) In any case in which an individual visits a field office of the Social Security Administration and represents during the visit to an officer or employee of the Social Security Administration in the office that the individual's visit is occasioned by—

(1) the receipt of a notice from the Social Security Administration indicating a time limit for response by the individual, or

(2) the theft, loss, or nonreceipt of a benefit payment under this title,

the Secretary shall ensure that the individual is granted a face-to-face interview at the office with an officer or employee of the Social Security Administration before the close of business on the day of the visit.[169]

REPRESENTATION OF CLAIMANTS

SEC. 206. [42 U.S.C. 406] (a)(1)[170] The Secretary may prescribe rules and regulations governing the recognition of agents or other persons, other than attorneys as hereinafter provided, representing claimants before the Secretary, and may require of such agents or other persons, before being recognized as representatives of claimants that they shall show that they are of good character and in good repute, possessed of the necessary qualifications to enable them to render such claimants valuable service, and otherwise competent to advise and assist such claimants in the presentation of their cases.

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[168] P.L. 101-508, §5109(a)(1), added subsection (s), applicable to notices issued on or after July 1, 1991.

[169] P.L. 101-239, §10303(a), added subsection (t), applicable to visits to field offices of the Social Security Administration on or after January 1, 1990.

[170] P.L. 101-508, §5106(a)(1)(A), redesignated subsection (a) as paragraph (a)(1).

An attorney in good standing who is admitted to practice before the highest court of the State, Territory, District, or insular possession of his residence or before the Supreme Court of the United States or the inferior Federal courts, shall be entitled to represent claimants before the Secretary. The Secretary may, after due notice and opportunity for hearing, suspend or prohibit from further practice before him any such person, agent, or attorney who refuses to comply with the Secretary's rules and regulations or who violates any provision of this section for which a penalty is prescribed. The Secretary may, by rule and regulation, prescribe the maximum fees which may be charged for services performed in connection with any claim before the Secretary under this title, and any agreement in violation of such rules and regulations shall be void. Except as provided in paragraph (2)(A), whenever[171] the Secretary, in any claim before him for benefits under this title, makes a determination favorable to the claimant, he shall, if the claimant was represented by an attorney in connection with such claim, fix (in accordance with the regulations prescribed pursuant to the preceding sentence) a reasonable fee to compensate such attorney for the services performed by him in connection with such claim.

(2)(A) In the case of a claim of entitlement to past-due benefits under this title, if—

(i) an agreement between the claimant and another person regarding any fee to be recovered by such person to compensate such person for services with respect to the claim is presented in writing to the Secretary prior to the time of the Secretary's determination regarding the claim,

(ii) the fee specified in the agreement does not exceed the lesser of—

(I) 25 percent of the total amount of such past-due benefits (as determined before any applicable reduction under section 1127(a)), or

(II) $4,000, and

(iii) the determination is favorable to the claimant,

then the Secretary shall approve that agreement at the time of the favorable determination, and (subject to paragraph (3)) the fee specified in the agreement shall be the maximum fee. The Secretary may from time to time increase the dollar amount under clause (ii)(II) to the extent that the rate of increase in such amount, as determined over the period since January 1, 1991, does not at any time exceed the rate of increase in primary insurance amounts under section 215(i) since such date. The Secretary shall publish any such increased amount in the Federal Register.

(B) For purposes of this subsection, the term "past-due benefits" excludes any benefits with respect to which payment has been continued pursuant to subsection (g) or (h) of section 223.

(C) In the case of a claim with respect to which the Secretary has approved an agreement pursuant to subparagraph (A), the Secretary shall provide the claimant and the person representing the claimant a written notice of—

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[171] P.L. 101-508, §5106(a)(1)(B), struck out "Whenever" and substituted "Except as provided in paragraph (2)(A), whenever", applicable to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after April 1, 1991.

(i) the dollar amount of the past-due benefits (as determined before any applicable reduction under section 1127(a)) and the dollar amount of the past-due benefits payable to the claimant,

(ii) the dollar amount of the maximum fee which may be charged or recovered as determined under this paragraph, and

(iii) a description of the procedures for review under paragraph (3).[172]

(3)(A) The Secretary shall provide by regulation for review of the amount which would otherwise be the maximum fee as determined under paragraph (2) if, within 15 days after receipt of the notice provided pursuant to paragraph (2)(C)—

(i) the claimant, or the administrative law judge or other adjudicator who made the favorable determination, submits a written request to the Secretary to reduce the maximum fee, or

(ii) the person representing the claimant submits a written request to the Secretary to increase the maximum fee.

Any such review shall be conducted after providing the claimant, the person representing the claimant, and the adjudicator with reasonable notice of such request and an opportunity to submit written information in favor of or in opposition to such request. The adjudicator may request the Secretary to reduce the maximum fee only on the basis of evidence of the failure of the person representing the claimant to represent adequately the claimant's interest or on the basis of evidence that the fee is clearly excessive for services rendered.

(B)(i) In the case of a request for review under subparagraph (A) by the claimant or by the person representing the claimant, such review shall be conducted by the administrative law judge who made the favorable determination or, if the Secretary determines that such administrative law judge is unavailable or if the determination was not made by an administrative law judge, such review shall be conducted by another person designated by the Secretary for such purpose.

(ii) In the case of a request by the adjudicator for review under subparagraph (A), the review shall be conducted by the Secretary or by an administrative law judge or other person (other than such adjudicator) who is designated by the Secretary.

(C) Upon completion of the review, the administrative law judge or other person conducting the review shall affirm or modify the amount which would otherwise be the maximum fee. Any such amount so affirmed or modified shall be considered the amount of the maximum fee which may be recovered under paragraph (2). The decision of the administrative law judge or other person conducting the review shall not be subject to further review.[173]

(4)(A) Subject to subparagraph (B), if the claimant is determined to be entitled to past-due benefits under this title and the person representing the claimant is an attorney, the Secretary shall, notwithstanding section 205(i), certify for payment out of such past-due benefits (as determined before any applicable reduction under section 1127(a)) to such attorney an amount equal to so much of the maximum fee as does not exceed 25 percent of such past-due benefits (as determined before any applicable reduction under section 1127(a)).

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[172] P.L. 101-508, §5106(a)(1)(C), struck out "If as a result of such determination, such claimant is entitled to past-due benefits under this title, the Secretary shall, notwithstanding section 205(i), certify for payment (out of such past-due benefits) to such attorney an amount equal to whichever of the following is the smaller: (A) 25 per centum of the total amount of such past-due benefits, (B) the amount of the attorney's fee so fixed, or (C) the amount agreed upon between the claimant and such attorney as the fee for such attorney's services." and substituted subparagraph (2), applicable to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after April 1, 1991.

[173] P.L. 101-508, §5106(a)(1)(C), added paragraph (3), applicable to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after April 1, 1991.

(B) The Secretary shall not in any case certify any amount for payment to the attorney pursuant to this paragraph before the expiration of the 15-day period referred to in paragraph (3)(A) or, in the case of any review conducted under paragraph (3), before the completion of such review.[174]

(5) Any[175] person who shall, with intent to defraud, in any manner willfully and knowingly deceive, mislead, or threaten any claimant or prospective claimant or beneficiary under this title by word, circular, letter or advertisement, or who shall knowingly charge or collect directly or indirectly any fee in excess of the maximum fee, or make any agreement directly or indirectly to charge or collect any fee in excess of the maximum fee, prescribed by the Secretary shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall for each offense be punished by a fine not exceeding $500 or by imprisonment not exceeding one year, or both. The Secretary shall maintain in the electronic information retrieval system used by the Social Security Administration a current record, with respect to any claimant before the Secretary, of the identity of any person representing such claimant in accordance with this subsection.[176]

(b)(1) Whenever a court renders a judgment favorable to a claimant under this title who was represented before the court by an attorney, the court may determine and allow as part of its judgment a reasonable fee for such representation, not in excess of 25 percent of the total of the past-due benefits to which the claimant is entitled by reason of such judgment, and the Secretary may, notwithstanding the provisions of section 205(i), certify the amount of such fee for payment to such attorney out of, and not in addition to, the amount of such past-due benefits. In case of any such judgment, no other fee may be payable or certified for payment for such representation except as provided in this paragraph.

(2) Any attorney who charges, demands, receives, or collects for services rendered in connection with proceedings before a court to which paragraph (1) is applicable any amount in excess of that allowed by the court thereunder shall be guilty of a misdemeanor and upon conviction thereof shall be subject to a fine of not more than $500, or imprisonment for not more than one year, or both.[177]

(c) The Secretary shall notify each claimant in writing, together with the notice to such claimant of an adverse determination, of the options for obtaining attorneys to represent individuals in presenting their cases before the Secretary. Such notification shall also advise the claimant of the availability to qualifying claimants of legal services organizations which provide legal services free of charge.[178]

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[174] P.L. 101-508, §5106(a)(1)(C), added paragraph (4), applicable to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after April 1, 1991.

[175] P.L. 101-508, §5106(a)(1)(C), struck out "Any" and substituted "(5) Any".

[176] P.L. 101-239, §10307(a)(1), added this sentence, effective June 1, 1991.

[177] See Vol. II, P.L. 96-481, with respect to an award of attorney fees and other expenses.

[178] P.L. 101-239, §10307(b)(1), added subsection (c), applicable with respect to adverse determinations made on or after January 1, 1991.

ASSIGNMENT[179]

SEC. 207. [42 U.S.C. 407] (a) The right of any person to any future payment under this title shall not be transferable or assignable, at law or in equity, and none of the moneys paid or payable or rights existing under this title shall be subject to execution, levy, attachment, garnishment, or other legal process, or to the operation of any bankruptcy or insolvency law.

(b) No other provision of law, enacted before, on, or after the date of the enactment of this section[180], may be construed to limit, supersede, or otherwise modify the provisions of this section except to the extent that it does so by express reference to this section.

PENALTIES[181]

SEC. 208. [42 U.S.C. 408] (a) [182] Whoever—

(1)[183] for the purpose of causing an increase in any payment authorized to be made under this title, or for the purpose of causing any payment to be made where no payment is authorized under this title, shall make or cause to be made any false statement or representation (including any false statement or representation in connection with any matter arising under subchapter E of chapter 1, or subchapter A or E of chapter 9 of the Internal Revenue Code of 1939[184], or chapter 2 or 21 or subtitle F of the Internal Revenue Code of 1954[185]) as to—

(A)[186] whether wages were paid or received for employment (as said terms are defined in this title and the Internal Revenue Code), or the amount of wages or the period during which paid or the person to whom paid; or

(B)[187] whether net earnings from self-employment (as such term is defined in this title and in the Internal Revenue Code) were derived, or as to the amount of such net earnings or the period during which or the person by whom derived; or

(C)[188] whether a person entitled to benefits under this title had earnings in or for a particular period (as determined under section 203(f) of this title for purposes of deductions from benefits), or as to the amount thereof; or

(2)[189] makes or causes to be made any false statement or representation of a material fact in any application for any payment or for a disability determination under this title; or

(3)[190] at any time makes or causes to be made any false statement or representation of a material fact for use in determining rights to payment under this title; or

(4)[191] having knowledge of the occurrence of any event affecting (1) his initial or continued right to any payment under this title, or (2) the initial or continued right to any payment of any other individual in whose behalf he has applied for or is receiving such payment, conceals or fails to disclose such event with an intent fraudulently to secure payment either in a greater amount than is due or when no payment is authorized; or

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[179] See Vol. II, P.L. 83-591, §§86, 861, and 871, with respect to income subject to taxes.

[180] This section was enacted August 10, 1939, [P.L. 76-379, §207].

This subsection was enacted April 20, 1983, [P.L. 98-21, §335(a)(2)].

[181] See Vol. II, 18 U.S.C. 1028 and 1738, with respect to penalties relating to use of identification documents.

[182] P.L. 101-508, §5121(b)(4), inserted "(a)".

[183] P.L. 101-508, §5121(b)(3), redesignated subsection (a) as paragraph (1).

[184] P.L. 76-1.

[185] See P.L. 83-591, chapter 2; (this volume).

[186] P.L. 101-508, §5121(b)(1), redesignated paragraph (1) as subparagraph (A).

[187] P.L. 101-508, §5121(b)(1), redesignated paragraph (2) as subparagraph (B).

[188] P.L. 101-508, §5121(b)(1), redesignated paragraph (3) as subparagraph (C).

[189] P.L. 101-508, §5121(b)(3), redesignated subsection (b) as paragraph (2).

[190] P.L. 101-508, §5121(b)(3), redesignated subsection (c) as paragraph (3).

[191] P.L. 101-508, §5121(b)(3), redesignated subsection (d) as paragraph (4).

(5)[192] having made application to receive payment under this title for the use and benefit of another and having received such a payment, knowingly and willfully converts such a payment, or any part thereof, to a use other than for the use and benefit of such other person; or

(6)[193] willfully, knowingly, and with intent to deceive the Secretary as to his true identity (or the true identity of any other person) furnishes or causes to be furnished false information to the Secretary with respect to any information required by the Secretary in connection with the establishment and maintenance of the records provided for in section 205(c)(2); or

(7)[194] for the purpose of causing an increase in any payment authorized under this title (or any other program financed in whole or in part from Federal funds), or for the purpose of causing a payment under this title (or any such other program) to be made when no payment is authorized thereunder, or for the purpose of obtaining (for himself or any other person) any payment or any other benefit to which he (or such other person) is not entitled, or for the purpose of obtaining anything of value from any person, or for any other purpose—

> (A)[195] willfully, knowingly, and with intent to deceive, uses a social security account number, assigned by the Secretary (in the exercise of his authority under section 205(c)(2) to establish and maintain records) on the basis of false information furnished to the Secretary by him or by any other person; or
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> (B)[196] with intent to deceive, falsely represents a number to be the social security account number assigned by the Secretary to him or to another person, when in fact such number is not the social security account number assigned by the Secretary to him or to such other person; or
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> (C)[197] knowingly alters a social security card issued by the Secretary, buys or sells a card that is, or purports to be, a card so issued, counterfeits a social security card, or possesses a social security card or counterfeit social security card with intent to sell or alter it; or

(8)[198] discloses, uses, or compels the disclosure of the social security number of any person in violation of the laws of the United States;[199]

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[192] P.L. 101-508, §5121(b)(3), redesignated subsection (e) as paragraph (5).

[193] P.L. 101-508, §5121(b)(3), redesignated subsection (f) as paragraph (6).

[194] P.L. 101-508, §5121(b)(3), redesignated subsection (g) as paragraph (7).

[195] P.L. 101-508, §5121(b)(2), redesignated paragraph (1) as subparagraph (A).

[196] P.L. 101-508, §5121(b)(2), redesignated paragraph (2) as subparagraph (B).

[197] P.L. 101-508, §5121(b)(2), redesignated paragraph (3) as subparagraph (C).

[198] P.L. 101-508, §5121(b)(3), redesignated subsection (h) as paragraph (8).

[199] See Vol. II, P.L. 80-759, §12(e), with respect to disclosures to facilitate selective service registration.

shall be guilty of a felony and upon conviction thereof shall be fined under title 18, United States Code, or imprisoned for not more than five years, or both.

(b)[200] Any person or other entity who is convicted of a violation of any of the provisions of this section, if such violation is committed by such person or entity in his role as, or in applying to become, a certified payee under section 205(j) on behalf of another individual (other than such person's spouse), upon his second or any subsequent such conviction shall, in lieu of the penalty set forth in the preceding provisions of this section, be guilty of a felony and shall be fined under title 18, United States Code, or imprisoned for not more than five years, or both. In the case of any violation described in the preceding sentence, including a first such violation, if the court determines that such violation includes a willful misuse of funds by such person or entity, the court may also require that full or partial restitution of such funds be made to the individual for whom such person or entity was the certified payee.

(c)[201] Any individual or entity convicted of a felony under this section or under section 1632(b) may not be certified as a payee under section 205(j). For the purpose of subsection (g), the terms "social security number" and "social security account number" mean such numbers as are assigned by the Secretary under section 205(c)(2)[202] whether or not, in actual use, such numbers are called social security numbers.

(d)(1) Except as provided in paragraph (2), an alien—

(A) whose status is adjusted to that of lawful temporary resident under section 210 or 245A of the Immigration and Nationality Act or under section 902 of the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989,

(B) whose status is adjusted to that of permanent resident—

(i) under section 202 of the Immigration Reform and Control Act of 1986, or

(ii) pursuant to section 249 of the Immigration and Nationality Act, or

(C) who is granted special immigrant status under section 101(a)(27)(I) of the Immigration and Nationality Act,

shall not be subject to prosecution for any alleged conduct described in paragraph (6) or (7) of subsection (a) if such conduct is alleged to have occurred prior to 60 days after the date of the enactment of the Omnibus Budget Reconciliation Act of 1990.

(2) Paragraph (1) shall not apply with respect to conduct (described in subsection (a)(7)(C)) consisting of—

(A) selling a card that is, or purports to be, a social security card issued by the Secretary,

(B) possessing a social security card with intent to sell it, or

(C) counterfeiting a social security card with intent to sell it.

(3) Paragraph (1) shall not apply with respect to any criminal conduct involving both the conduct described in subsection (a)(7) to which paragraph (1) applies and any other criminal conduct if such other conduct would be criminal conduct if the conduct described in subsection (a)(7) were not committed.[203]

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[200] P.L. 101-508, §5121(b)(5), inserted "(b)".

[201] P.L. 101-508, §5121(b)(6), inserted "(c)".

[202] P.L. 101-508, §5130(a)(1), struck out "405(c)(2) of this title" and substituted "205(c)(2)", effective as if included in the enactment of P.L. 100-690.

[203] P.L. 101-508, §5121(a), added subsection (d), effective November 5, 1990.

DEFINITION OF WAGES

Sec. 209. [42 U.S.C. 409] (a)[204] For the purposes of this title, the term "wages" means remuneration paid prior to 1951 which was wages for the purposes of this title under the law applicable to the payment of such remuneration, and remuneration paid after 1950 for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash; except that, in the case of remuneration paid after 1950, such term shall not include—

(1)[205](A)[206] That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $3,600 with respect to employment has been paid to an individual during any calendar year prior to 1955, is paid to such individual during such calendar year;

(B)[207] That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $4,200 with respect to employment has been paid to an individual during any calendar year after 1954 and prior to 1959, is paid to such individual during such calendar year;

(C)[208] That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $4,800 with respect to employment has been paid to an individual during any calendar year after 1958 and prior to 1966, is paid to such individual during such calendar year;

(D)[209] That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $6,600 with respect to employment has been paid to an individual during any calendar year after 1965 and prior to 1968, is paid to such individual during such calendar year;

(E)[210] That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $7,800 with respect to employment has been paid to an individual during any calendar year after 1967 and prior to 1972, is paid to such individual during such calendar year;

(F)[211] That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $9,000 with respect to employment has been paid to an individual during any calendar year after 1971 and prior to 1973, is paid to such individual during any such calendar year;

(G)[212] That part of remuneration which, after remuneration

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[204] P.L. 101-239, §10208(d)(1)(K), inserted "(a)".

[205] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (a) as paragraph (1).

[206] P.L. 101-239, §10208(d)(1)(A), redesignated paragraph (1) as subparagraph (A).

[207] P.L. 101-239, §10208(d)(1)(A), redesignated paragraph (2) as subparagraph (B).

[208] P.L. 101-239, §10208(d)(1)(A), redesignated paragraph (3) as subparagraph (C).

[209] P.L. 101-239, §10208(d)(1)(A), redesignated paragraph (4) as subparagraph (D).

[210] P.L. 101-239, §10208(d)(1)(A), redesignated paragraph (5) as subparagraph (E).

[211] P.L. 101-239, §10208(d)(1)(A), redesignated paragraph (6) as subparagraph (F).

[212] P.L. 101-239, §10208(d)(1)(A), redesignated paragraph (7) as subparagraph (G).

(other than remuneration referred to in the succeeding subsections of this section) equal to $10,800 with respect to employment has been paid to an individual during any calendar year after 1972 and prior to 1974, is paid to such individual during such calendar year;

(H)[213] That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $13,200 with respect to employment has been paid to an individual during any calendar year after 1973 and prior to 1975, is paid to such individual during such calendar year;

(I)[214] That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to the contribution and benefit base (determined under section 230) with respect to employment has been paid to an individual during any calendar year after 1974 with respect to which such contribution and benefit base is effective, is paid to such individual during such calendar year;

(2)[215] The amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of his dependents under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally and their dependents) or for a class or classes of his employees (or for a class or classes of his employees and their dependents), on account of (A)[216] sickness or accident disability (but, in the case of payments made to an employee or any of his dependents, this clause shall exclude from the term "wages" only payments which are received under a workmen's compensation law), or[217] (B)[218] medical or hospitalization expenses in connection with sickness or accident disability, or (C)[219] death, except that this subsection does not apply to a payment for group-term life insurance to the extent that such payment is includible in the gross income of the employee under the Internal Revenue Code of 1986;

(3)[220] Any payment on account of sickness or accident disability, or medical or hospitalization expenses in connection with sickness or accident disability, made by an employer to, or on behalf of, an employee after the expiration of six calendar months following the last calendar month in which the employee worked for such employer;

(4)[221] Any payment made to, or on behalf of, an employee or his beneficiary (A)[222] from or to a trust exempt from tax under section 165(a) of the Internal Revenue Code of 1939[223] at the time of such payment or, in the case of a payment after 1954, under sections 401 and 501(a) of the Internal Revenue Code of 1954[224], unless such payment is made to an employee of the trust as remuneration for services rendered as such employee and not as a beneficiary of the trust, or (B)[225] under or to an annuity plan which, at the time of such payment, meets the requirements of section 165(a)(3), (4), (5), and (6) of the Internal Revenue Code of 1939[226] or, in the case of a payment after 1954 and prior to 1963, the requirements of section 401(a)(3), (4), (5), and (6) of the Internal Revenue Code of 1954, or (C)[227] under or to an annuity plan which, at the time of any such payment after 1962, is a plan described in section 403(a) of the Internal Revenue Code of 1954, or (D)[228] under or to a bond purchase plan which, at the time of any such payment after 1962, is a qualified bond purchase plan described in section 405(a) of the Internal Revenue Code of 1954 (as in effect before the enactment of the Tax Reform Act of 1984), or (E)[229] under or to an annuity contract described in section 403(b) of the Internal Revenue Code of 1954, other than a payment for the purchase of such contract which is made by reason of a salary reduction agreement (whether evidenced by a written instrument or otherwise), or (F)[230] under or to an exempt governmental deferred compensation plan (as defined in section 3121(v)(3) of such Code[231]), or (G)[232] to supplement pension benefits under a plan or trust described in any of the foregoing provisions of this subsection to take into account some portion or all of the increase in the cost of living (as determined by the Secretary of Labor) since retirement but only if such supplemental payments are under a plan which is treated as a welfare plan under section 3(2)(B)(ii) of the Employee Retirement Income Security Act of 1974[233], or (H)[234] under a simplified employee pension (as defined in section 408(k)(1) of such Code), other than any contributions described in section 408(k)(6) of such Code, (I)[235] under a cafeteria plan (within the meaning of section 125 of the Internal Revenue Code of 1986) if such payment would not be treated as wages without regard to such plan and it is reasonable to believe that (if section 125 applied for purposes of this section) section 125 would not treat any wages as constructively received[236];

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[213] P.L. 101-239, §10208(d)(1)(A), redesignated paragraph (8) as subparagraph (H).

[214] P.L. 101-239, §10208(d)(1)(A), redesignated paragraph (9) as subparagraph (I).

[215] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (b) as paragraph (2).

[216] P.L. 101-239, §10208(d)(1)(B), redesignated clause (1) as clause (A).

[217] See Vol. II, P.L. 97-123, §3(e), with respect to treatment of payments under a State temporary disability law.

[218] P.L. 101-239, §10208(d)(1)(B), redesignated clause (2) as clause (B).

[219] P.L. 101-239, §10208(d)(1)(B), redesignated clause (3) as clause (C).

[220] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (d) as paragraph (3).

[221] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (e) as paragraph (4).

[222] P.L. 101-239, §10208(d)(1)(C), redesignated clause (1) as clause (A).

[223] P.L. 76-1.

(5)[237] The payment by an employer (without deduction from the remuneration of the employee)—

(A)[238] of the tax imposed upon an employee under section 3101 of the Internal Revenue Code of 1954[239], or

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[224] P.L. 83-591.

[225] P.L. 101-239, §10208(d)(1)(C), redesignated clause (2) as clause (B).

[226] P.L. 76-1.

[227] P.L. 101-239, §10208(d)(1)(C), redesignated clause (3) as clause (C).

[228] P.L. 101-239, §10208(d)(1)(C), redesignated clause (4) as clause (D).

[229] P.L. 101-239, §10208(d)(1)(C), redesignated clause (5) as clause (E).

[230] P.L. 101-239, §10208(d)(1)(C), redesignated clause (6) as clause (F).

[231] See P.L. 83-591, §3121(v); (this volume).

[232] P.L. 101-239, §10208(d)(1)(C), redesignated clause (7) as clause (G).

[233] P.L. 93-406.

[234] P.L. 101-239, §10208(d)(1)(C), redesignated clause (8) as clause (H).

[235] P.L. 101-239, §10208(d)(1)(C), redesignated clause (9) as clause (I).

[236] P.L. 99-514, §2, provides, except when inappropriate, any reference to the Internal Revenue Code of 1986 shall include a reference to the provisions of law formerly known as the Internal Revenue Code of 1954.

[237] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (f) as paragraph (5).

[238] P.L. 101-239, §10208(d)(1)(D), redesignated paragraph (1) as subparagraph (A).

[239] See P.L. 83-591, §3101; (this volume).

(B)[240] of any payment required from an employee under a State unemployment compensation law,

with respect to remuneration paid to an employee for domestic service in a private home of the employer or for agricultural labor;

(6)[241] (A)[242] Remuneration paid in any medium other than cash to an employee for service not in the course of the employer's trade or business or for domestic service in a private home of the employer;

(B)[243] Cash remuneration paid by an employer in any calendar quarter to an employee for domestic service in a private home of the employer, if the cash remuneration paid in such quarter by the employer to the employee for such service is less than $50. As used in this paragraph, the term "domestic service in a private home of the employer" does not include service described in section 210(f)(5);

(C)[244] Cash remuneration paid by an employer in any calendar year to an employee for service not in the course of the employer's trade or business, if the cash remuneration paid in such year by the employer to the employee for such service is less than $100. As used in this paragraph, the term "service not in the course of the employer's trade or business" does not include domestic service in a private home of the employer and does not include service described in section 210(f)(5);

(7)[245] (A)[246] Remuneration paid in any medium other than cash for agricultural labor;

(B)[247] Cash remuneration paid by an employer in any calendar year to an employee for agricultural labor unless—

(i)[248] the cash remuneration paid in such year by the employer to the employee for such labor is $150 or more, or

(ii)[249] the employer's expenditures for agricultural labor in such year equal or exceed $2,500,

except that clause (ii)[250] shall not apply in determining whether remuneration paid to an employee constitutes "wages" under this section if such employee (I)[251] is employed as a hand harvest laborer and is paid on a piece rate basis in an operation which has been, and is customarily and generally recognized as having been, paid on a piece rate basis in the region of employment, (II)[252] commutes daily from his permanent residence to the farm on which he is so employed, and (III)[253] has been employed in agriculture less than 13 weeks during the preceding calendar year;

(8)[254] Remuneration paid by an employer in any year to an employee for service described in section 210(j)(3)(C) (relating to home workers), if the cash remuneration paid in such year by the employer to the employee for such service is less than $100;

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[240] P.L. 101-239, §10208(d)(1)(D), redesignated paragraph (2) as subparagraph (B).

[241] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (g) as paragraph (6).

[242] P.L. 101-239, §10208(d)(1)(E), redesignated paragraph (1) as subparagraph (A).

[243] P.L. 101-239, §10208(d)(1)(E), redesignated paragraph (2) as subparagraph (B).

[244] P.L. 101-239, §10208(d)(1)(E), redesignated paragraph (3) as subparagraph (C).

[245] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (h) as paragraph (7).

[246] P.L. 101-239, §10208(d)(1)(F), redesignated paragraph (1) as subparagraph (A).

[247] P.L. 101-239, §10208(d)(1)(F), redesignated paragraph (2) as subparagraph (B).

[248] P.L. 101-239, §10208(d)(1)(F), redesignated subparagraph (A) as clause (i).

[249] P.L. 101-239, §10208(d)(1)(F), redesignated subparagraph (B) as clause (ii).

[250] P.L. 101-508, §5130(a)(5), struck out "subparagraph (B)" and substituted "clause (ii)", effective as if included in the enactment of P.L. 101-239.

[251] P.L. 101-239, §10208(d)(1)(F), redesignated clause (i) as clause (I).

[252] P.L. 101-239, §10208(d)(1)(F), redesignated clause (ii) as clause (II).

[253] P.L. 101-239, §10208(d)(1)(F), redesignated clause (iii) as clause (III).

[254] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (j) as paragraph (8).

(9)[255] Remuneration paid to or on behalf of an employee if (and to the extent that) at the time of the payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 217 of the Internal Revenue Code of 1986 (determined without regard to section 274(n) of such Code);

(10)[256](A)[257] Tips paid in any medium other than cash;

(B)[258] Cash tips received by an employee in any calendar month in the course of his employment by an employer unless the amount of such cash tips is $20 or more;

(11)[259] Any payment or series of payments by an employer to an employee or any of his dependents which is paid—

> (A)[260] upon or after the termination of an employee's employment relationship because of (A) death, or (B) retirement for disability, and
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> (B)[261] under a plan established by the employer which makes provision for his employees generally or a class or classes of his employees (or for such employees or class or classes of employees and their dependents),

other than any such payment or series of payments which would have been paid if the employee's employment relationship had not been so terminated;

(12)[262] Any payment made by an employer to a survivor or the estate of a former employee after the calendar year in which such employee died;

(13)[263] Any payment made by an employer to an employee, if at the time such payment is made such employee is entitled to disability insurance benefits under section 223(a) and such entitlement commenced prior to the calendar year in which such payment is made, and if such employee did not perform any services for such employer during the period for which such payment is made;

(14)[264] (A)[265] Remuneration paid by an organization exempt from income tax under section 501 of the Internal Revenue Code of 1954[266] in any calendar year to an employee for service rendered in the employ of such organization, if the remuneration paid in such year by the organization to the employee for such service is less than $100;

(B)[267] Any contribution, payment, or service, provided by an employer which may be excluded from the gross income of an employee, his spouse, or his dependents, under the provisions of section 120 of the Internal Revenue Code of 1954 (relating to amounts received under qualified group legal services plans);

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[255] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (k) as paragraph (9).

[256] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (l) as paragraph (10).

[257] P.L. 101-239, §10208(d)(1)(G), redesignated paragraph (1) as subparagraph (A).

[258] P.L. 101-239, §10208(d)(1)(G), redesignated paragraph (2) as subparagraph (B).

[259] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (m) as paragraph (11).

[260] P.L. 101-239, §10208(d)(1)(H), redesignated paragraph (1) as subparagraph (A).

[261] P.L. 101-239, §10208(d)(1)(H), redesignated paragraph (2) as subparagraph (B).

[262] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (n) as paragraph (12).

[263] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (o) as paragraph (13).

[264] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (p) as paragraph (14).

[265] P.L. 101-239, §10208(d)(1)(I), redesignated paragraph (1) as subparagraph (A).

[266] P.L. 83-591.

[267] P.L. 101-239, §10208(d)(1)(I), redesignated paragraph (2) as subparagraph (B).

(15)[268] Any payment made, or benefit furnished, to or for the benefit of an employee if at the time of such payment or such furnishing it is reasonable to believe that the employee will be able to exclude such payment or benefit from income under section 127 or 129 of the Internal Revenue Code of 1954;

(16)[269] The value of any meals or lodging furnished by or on behalf of the employer if at the time of such furnishing it is reasonable to believe that the employee will be able to exclude such items from income under section 119 of the Internal Revenue Code of 1954;

(17)[270] Any benefit provided to or on behalf of an employee if at the time such benefit is provided it is reasonable to believe that the employee will be able to exclude such benefit from income under section 74(c), 117, or 132 of the Internal Revenue Code of 1954; or

(18)[271] Remuneration consisting of income excluded from taxation under section 7873 of the Internal Revenue Code of 1986 (relating to income derived by Indians from exercise of fishing rights).

(b)[272] Nothing in the regulations prescribed for purposes of chapter 24 of the Internal Revenue Code of 1954[273] (relating to income tax withholding) which provides an exclusion from "wages" as used in such chapter shall be construed to require a similar exclusion from "wages" in the regulations prescribed for purposes of this title.

(c)[274] For purposes of this title, in the case of domestic service described in subsection (a)(6)(B)[275], any payment of cash remuneration for such service which is more or less than a whole-dollar amount shall, under such conditions and to such extent as may be prescribed by regulations made under this title, be computed to the nearest dollar. For the purpose of the computation to the nearest dollar, the payment of a fractional part of a dollar shall be disregarded unless it amounts to one-half dollar or more, in which case it shall be increased to $1. The amount of any payment of cash remuneration so computed to the nearest dollar shall, in lieu of the amount actually paid, be deemed to constitute the amount of cash remuneration for purposes of subsection (a)(6)(B)[276].

(d)[277] For purposes of this title, in the case of an individual performing service, as a member of a uniformed service, to which the provisions of section 210(l)(1) are applicable, the term "wages" shall, subject to the provisions of subsection (a)(1)[278] of this section, include as such individual's remuneration for such service only (1) his basic pay as described in chapter 3 and section 1009 of title 37, United States Code, in the case of an individual performing service to which subparagraph (A) of such section 210(l)(1) applies, or (2) his compensation for such service as determined under section 206(a) of title 37, United States Code, in the case of an individual performing service to which subparagraph (B) of such section 210(l)(1) applies.[279]

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[268] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (q) as paragraph (15).

[269] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (r) as paragraph (16).

[270] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (s) as paragraph (17).

[271] P.L. 101-239, §10208(d)(1)(J), redesignated subsection (t) as paragraph (18).

[272] P.L. 101-239, §10208(d)(1)(L), inserted "(b)".

[273] See P.L. 83-591, chapter 24; (this volume).

[274] P.L. 101-239, §10208(d)(1)(M), inserted "(c)".

[275] P.L. 101-239, §10208(d)(1)(M), struck out "subsection (g)(2)" and substituted "subsection (a)(6)(B)", effective December 19, 1989.

[276] P.L. 101-239, §10208(d)(1)(M), struck out "subsection (g)(2)" and substituted "subsection (a)(6)(B)", effective December 19, 1989.

[277] P.L. 101-239, §10208(d)(1)(N), inserted "(d)".

[278] P.L. 101-239, §10208(d)(1)(N), inserted "(1)", effective December 19, 1989.

(e)[280] For purposes of this title, in the case of an individual performing service, as a volunteer or volunteer leader within the meaning of the Peace Corps Act[281], to which the provisions of section 210(o) are applicable, (1) the term "wages" shall, subject to the provisions of subsection (a) of this section, include as such individual's remuneration for such service only amounts certified as payable pursuant to section 5(c) or 6(1) of the Peace Corps Act, and (2) any such amount shall be deemed to have been paid to such individual at the time the service, with respect to which it is paid, is performed.

(f)[282] For purposes of this title, tips received by an employee in the course of his employment shall be considered remuneration for employment. Such remuneration shall be deemed to be paid at the time a written statement including such tips is furnished to the employer pursuant to section 6053(a) of the Internal Revenue Code of 1954[283] or (if no statement including such tips is so furnished) at the time received.

(g)[284] For purposes of this title, in any case where an individual is a member of a religious order (as defined in section 3121(r)(2) of the Internal Revenue Code of 1954[285]) performing service in the exercise of duties required by such order, and an election of coverage under section 3121(r) of such Code is in effect with respect to such order or with respect to the autonomous subdivision thereof to which such member belongs, the term "wages" shall, subject to the provisions of subsection (a) of this section, include as such individual's remuneration for such service the fair market value of any board, lodging, clothing, and other perquisites furnished to such member by such order or subdivision thereof or by any other person or organization pursuant to an agreement with such order or subdivision, except that the amount included as such individual's remuneration under this paragraph shall not be less than $100 a month.

(h)[286] For purposes of this title, in the case of an individual performing service under the provisions of section 294 of title 28, United States Code (relating to assignment of retired justices and judges to active duty), the term "wages" shall not include any payment under section 371(b) of such title 28 which is received during the period of such service.[287]

(i)[288] Nothing in any of the foregoing provisions of this section (other than subsection (a)) shall exclude from the term "wages"—

(1) Any employer contribution under a qualified cash or deferred arrangement (as defined in section 401(k) of the Internal Revenue Code of 1954[289]) to the extent not included in gross income by reason of section 402(a)(8) of such Code, or

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[279] See Vol. II, P.L. 100-456, §601(a) and (b), with respect to compensation of members of the uniformed services.

[280] P.L. 101-239, §10208(d)(1)(O), inserted "(e)".

[281] P.L. 87-293.

[282] P.L. 101-239, §10208(d)(1)(P), inserted "(f)".

[283] P.L. 83-591.

[284] P.L. 101-239, §10208(d)(1)(Q), inserted "(g)".

[285] See P.L. 83-591, §3121(r); (this volume).

[286] P.L. 101-239, §10208(d)(1)(R), inserted "(h)".

[287] See Vol. II, P.L. 98-118, §4, with respect to coverage of retired Federal judges on active duty.

[288] P.L. 101-239, §10208(d)(1)(S), inserted "(i)".

[289] P.L. 83-591.

(2) Any amount which is treated as an employer contribution under section 414(h)(2) of such Code where the pickup referred to in such section is pursuant to a salary reduction agreement (whether evidenced by a written instrument or otherwise).[290]

(j)[291] Any amount deferred under a nonqualified deferred compensation plan (within the meaning of section 3121(v)(2)(C) of the Internal Revenue Code of 1954[292]) shall be taken into account for purposes of this title as of the later of when the services are performed, or when there is no substantial risk of forfeiture of the rights to such amount. Any amount taken into account as wages by reason of the preceding sentence (and the income attributable thereto) shall not thereafter be treated as wages for purposes of this title.

(k)(1) For purposes of sections 203(f)(8)(B)(ii), 213(d)(2)(B), 215(a)(1)(B)(ii), 215(b)(3)(A)(ii), 224(f)(2)(B), and 230(b)(2) (and 230(b)(2) as in effect immediately prior to the enactment of the Social Security Amendments of 1977), the term "deemed average total wages" for any particular calendar year means the product of—

(A) the SSA average wage index (as defined in section 215(i)(1)(G) and promulgated by the Secretary) for the calendar year preceding such particular calendar year, and

(B) the quotient obtained by dividing—

(i) the average of total wages (as defined in regulations of the Secretary and computed without regard to the limitation specified in subsection (a)(1) and by including deferred compensation amounts) reported to the Secretary of the Treasury or his delegate for such particular calendar year, by

(ii) the average of total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate for the calendar year preceding such particular calendar year.

(2) For purposes of paragraph (1), the term "deferred compensation amount" means—

(A) any amount excluded from gross income under chapter 1 of the Internal Revenue Code of 1986 by reason of section 402(a)(8), 402(h)(1)(B), or 457(a) of such Code or by reason of a salary reduction agreement under section 403(b) of such Code,

(B) any amount with respect to which a deduction is allowable under chapter 1 of such Code by reason of a contribution to a plan described in section 501(c)(18) of such Code, and

(C) to the extent provided in regulations of the Secretary, deferred compensation provided under any arrangement, agreement, or plan referred to in subsection (i) or (j).[293]

DEFINITION OF EMPLOYMENT

SEC. 210. [42 U.S.C. 410] For the purposes of this title—

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[290] P.L. 101-140, §203(a)(2), in effect, struck out paragraph (3), effective as if P.L. 100-647, §1011B(a)(22), had not been enacted. P.L. 101-140, §203(c), provides that §203(a)(2) shall take effect as if included in P.L. 99-514, §1151. See Vol. II, P.L. 99-514, §1151(k). Formerly, paragraph (3) read as follows: "Any amount required to be included in gross income under section 89 of the Internal Revenue Code of 1986.".

[291] P.L. 101-239, §10208(d)(1)(T), inserted "(j)".

[292] See P.L. 83-591, §3121(v); (this volume).

[293] P.L. 101-239, §10208(a), added this subsection (k), applicable with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

Employment

(a) The term "employment" means any service performed after 1936 and prior to 1951 which was employment for the purposes of this title under the law applicable to the period in which such service was performed, and any service, of whatever nature, performed after 1950 (A) by an employee for the person employing him, irrespective of the citizenship or residence of either, (i) within the United States, or (ii) on or in connection with an American vessel or American aircraft under a contract of service which is entered into within the United States or during the performance of which and while the employee is employed on the vessel or aircraft it touches at a port in the United States, if the employee is employed on and in connection with such vessel or aircraft when outside the United States, or (B) outside the United States by a citizen or resident of the United States as an employee (i) of an American employer (as defined in subsection (e) of this section), or (ii) of a foreign affiliate (as defined in section 3121(l)(6)[294] of the Internal Revenue Code of 1954[295]) of an American employer during any period for which there is in effect an agreement, entered into pursuant to section 3121(l) of such Code, with respect to such affiliate, or (C) if it is service, regardless of where or by whom performed, which is designated as employment or recognized as equivalent to employment under an agreement entered into under section 233; except that, in the case of service performed after 1950, such term shall not include—

(1) Service performed by foreign agricultural workers lawfully admitted to the United States from the Bahamas, Jamaica, and the other British West Indies, or from any other foreign country or possession thereof, on a temporary basis to perform agricultural labor;

(2) Domestic service performed in a local college club, or local chapter of a college fraternity or sorority, by a student who is enrolled and is regularly attending classes at a school, college, or university;

(3)(A) Service performed by a child under the age of 18 in the employ of his father or mother;

(B) Service not in the course of the employer's trade or business, or domestic service in a private home of the employer, performed by an individual under the age of 21 in the employ of his father or mother, or performed by an individual in the employ of his spouse or son or daughter; except that the provisions of this subparagraph shall not be applicable to such domestic service performed by an individual in the employ of his son or daughter if—

(i) the employer is a surviving spouse or a divorced individual and has not remarried, or has a spouse living in the home who has a mental or physical condition which results in such spouse's being incapable of caring for a son, daughter, stepson, or stepdaughter (referred to in clause (ii)) for at least 4 continuous weeks in the calendar quarter in which the service is rendered, and

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[294] P.L. 101-239, §10201(b)(1), struck out "(8)" and substituted "(6)", applicable with respect to any agreement in effect under section 3121(l) of the Internal Revenue Code of 1986 on or after June 15, 1989, with respect to which no notice of termination is in effect on such date.

[295] See P.L. 83-591, §3121(l); (this volume).

(ii) a son, daughter, stepson, or stepdaughter of such employer is living in the home, and

(iii) the son, daughter, stepson, or stepdaughter (referred to in clause (ii)) has not attained age 18 or has a mental or physical condition which requires the personal care and supervision of an adult for at least 4 continuous weeks in the calendar quarter in which the service is rendered;

(4) Service performed by an individual on or in connection with a vessel not an American vessel, or on or in connection with an aircraft not an American aircraft, if (A) the individual is employed on and in connection with such vessel or aircraft when outside the United States and (B)(i) such individual is not a citizen of the United States or (ii) the employer is not an American employer;

(5) Service performed in the employ of the United States or any instrumentality of the United States, if such service—

(A) would be excluded from the term "employment" for purposes of this title if the provisions of paragraphs (5) and (6) of this subsection as in effect in January 1983 had remained in effect, and

(B) is performed by an individual who—

(i) has been continuously performing service described in subparagraph (A) since December 31, 1983, and for purposes of this clause—

(I) if an individual performing service described in subparagraph (A) returns to the performance of such service after being separated therefrom for a period of less than 366 consecutive days, regardless of whether the period began before, on, or after December 31, 1983, then such service shall be considered continuous,

(II) if an individual performing service described in subparagraph (A) returns to the performance of such service after being detailed or transferred to an international organization as described under section 3343 of subchapter III of chapter 33 of title 5, United States Code, or under section 3581 of chapter 35 of such title, then the service performed for that organization shall be considered service described in subparagraph (A),

(III) if an individual performing service described in subparagraph (A) is reemployed or reinstated after being separated from such service for the purpose of accepting employment with the American Institute of Taiwan as provided under section 3310 of chapter 48 of title 22, United States Code, then the service performed for that Institute shall be considered service described in subparagraph (A),

(IV) if an individual performing service described in subparagraph (A) returns to the performance of such service after performing service as a member of a uniformed service (including, for purposes of this clause, service in the National Guard and temporary service in the Coast Guard Reserve) and after exercising restoration or reemployment rights as provided under chapter 43 of title 38, United States Code, then the service so performed as a member of a uniformed service shall be considered service described in subparagraph (A), and

(V) if an individual performing service described in subparagraph (A) returns to the performance of such service after employment (by a tribal organization) to which section 105(e)(2)[296] of the Indian Self-Determination Act applies, then the service performed for that tribal organization shall be considered service described in subparagraph (A); or

(ii) is receiving an annuity from the Civil Service Retirement and Disability Fund, or benefits (for service as an employee) under another retirement system established by a law of the United States for employees of the Federal Government (other than for members of the uniformed services);

except that this paragraph shall not apply with respect to any such service performed on or after any date on which such individual performs—

(C) service performed as the President or Vice President of the United States,

(D) service performed—

(i) in a position placed in the Executive Schedule under sections 5312 through 5317 of title 5, United States Code,[297]

(ii) as a noncareer appointee in the Senior Executive Service or a noncareer member of the Senior Foreign Service, or

(iii) in a position to which the individual is appointed by the President (or his designee) or the Vice President under section 105(a)(1), 106(a)(1), or 107(a)(1) or (b)(1) of title 3, United States Code, if the maximum rate of basic pay for such position is at or above the rate for level V of the Executive Schedule,

(E) service performed as the Chief Justice of the United States, an Associate Justice of the Supreme Court, a judge of a United States court of appeals, a judge of a United States district court (including the district court of a territory), a judge of the United States Claims Court, a judge of the United States Court of International Trade, a judge of the United States Tax Court, a United States magistrate, or a referee in bankruptcy or United States bankruptcy judge,

(F) service performed as a Member, Delegate, or Resident Commissioner of or to the Congress,

(G) any other service in the legislative branch of the Federal Government if such service—

(i) is performed by an individual who was not subject to subchapter III of chapter 83 of title 5, United States Code, or to another retirement system established by a law of the United States for employees of the Federal Government (other than for members of the uniformed services), on December 31, 1983, or

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[296] Probably should be "104(e)(2)". P.L. 100-472, §203(a), redesignated §105 as §104.

[297] See Vol. II, P.L. 100-456, §703(b), with respect to the pay of the General Counsel of a military department.

(ii) is performed by an individual who has, at any time after December 31, 1983, received a lump-sum payment under section 8342(a) of title 5, United States Code, or under the corresponding provision of the law establishing the other retirement system described in clause (i), or

(iii) is performed by an individual after such individual has otherwise ceased to be subject to subchapter III of chapter 83 of title 5, United States Code (without having an application pending for coverage under such subchapter), while performing service in the legislative branch (determined without regard to the provisions of subparagraph (B) relating to continuity of employment), for any period of time after December 31, 1983,

and for purposes of this subparagraph (G) an individual is subject to such subchapter III or to any such other retirement system at any time only if (a) such individual's pay is subject to deductions, contributions, or similar payments (concurrent with the service being performed at that time) under section 8334(a) of such title 5 or the corresponding provision of the law establishing such other system, or (in a case to which section 8332(k)(1) of such title applies) such individual is making payments of amounts equivalent to such deductions, contributions, or similar payments while on leave without pay, or (b) such individual is receiving an annuity from the Civil Service Retirement and Disability Fund, or is receiving benefits (for service as an employee) under another retirement system established by a law of the United States for employees of the Federal Government (other than for members of the uniformed services), or[298]

(H) service performed by an individual—

(i) on or after the effective date of an election by such individual, under section 301 of the Federal Employees' Retirement System Act of 1986[299] or section 307 of the Central Intelligence Agency Retirement Act of 1964 for Certain Employees[300], to become subject to the Federal Employees' Retirement System provided in chapter 84 of title 5, United States Code, or

(ii) on or after the effective date of an election by such individual, under regulations issued under section 860 of the Foreign Service Act of 1980[301], to become subject to the Foreign Service Pension System provided in subchapter II of chapter 8 of title I of such Act;

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[298] See Vol. II, P.L 98-369, §2601(c), with respect to the applicability of subchapter III, chapter 83, of Title 5, United States Code, to service performed after December 31, 1983; and §2601(e)(1), with respect to employees of certain nonprofit organizations who are considered to be performing services in the employ of an instrumentality of the United States.

See Vol. II, P.L. 99-190, §130, with respect to the provisions applicable to the position of Chief of the U.S.C. Capitol Police.

[299] P.L. 99-335.

[300] P.L. 88-643.

[301] P.L. 96-465.

(6) Service performed in the employ of the United States or any instrumentality of the United States if such service is performed—

(A) in a penal institution of the United States by an inmate thereof;

(B) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the Federal Government), other than as a medical or dental intern or a medical or dental resident in training; or

(C) by any individual as an employee serving on a temporary basis in case of fire, storm, earthquake, flood, or other similar emergency;

(7) Service performed in the employ of a State, or any political subdivision thereof, or any instrumentality of any one or more of the foregoing which is wholly owned thereby, except that this paragraph shall not apply in the case of—

(A) service included under an agreement under section 218,

(B) service which, under subsection (k), constitutes covered transportation service,

(C) service in the employ of the Government of Guam or the Government of American Samoa or any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, performed by an officer or employee thereof (including a member of the legislature of any such Government or political subdivision), and, for purposes of this title—

(i) any person whose service as such an officer or employee is not covered by a retirement system established by a law of the United States shall not, with respect to such service, be regarded as an officer or employee of the United States or any agency or instrumentality thereof, and

(ii) the remuneration for service described in clause (i) (including fees paid to a public official) shall be deemed to have been paid by the Government of Guam or the Government of American Samoa or by a political subdivision thereof or an instrumentality of any one or more of the foregoing which is wholly owned thereby, whichever is appropriate,

(D) service performed in the employ of the District of Columbia or any instrumentality which is wholly owned thereby, if such service is not covered by a retirement system established by a law of the United States; except that the provisions of this subparagraph shall not be applicable to service performed—

(i) in a hospital or penal institution by a patient or inmate thereof;

(ii) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or as a medical or dental resident in training;

(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency; or

(iv) by a member of a board, committee, or council of the District of Columbia, paid on a per diem, meeting, or other fee basis,[302]

(E) service performed in the employ of the Government of Guam (or any instrumentality which is wholly owned by such Government) by an employee properly classified as a temporary or intermittent employee, if such service is not covered by a retirement system established by a law of Guam; except that (i) the provisions of this subparagraph shall not be applicable to services performed by an elected official or a member of the legislature or in a hospital or penal institution by a patient or inmate thereof, and (ii) for purposes of this subparagraph, clauses (i) and (ii) of subparagraph (C) shall apply, or[303]

(F) service in the employ of a State (other than the District of Columbia, Guam, or American Samoa), of any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, by an individual who is not a member of a retirement system of such State, political subdivision, or instrumentality, except that the provisions of this subparagraph shall not be applicable to service performed—

(i) by an individual who is employed to relieve such individual from unemployment;

(ii) in a hospital, home, or other institution by a patient or inmate thereof;

(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency;

(iv) by an election official or election worker if the remuneration paid in a calendar year for such service is less than $100; or

(v) by an employee in a position compensated solely on a fee basis which is treated pursuant to section 211(c)(2)(E) as a trade or business for purposes of inclusion of such fees in net earnings from self employment;

for purposes of this subparagraph, except as provided in regulations prescribed by the Secretary of the Treasury, the term "retirement system" has the meaning given such term by section 218(b)(4).[304]

(8)(A) Service performed by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order, except that this subparagraph shall not apply to service performed by a member of such an order in the exercise of such duties, if an election of coverage under section 3121(r) of the Internal Revenue Code of 1954[305] is in effect with respect to such order, or with respect to the autonomous subdivision thereof to which such member belongs;

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[302] P.L. 101-508, §11332(a)(1), struck out "or".

[303] P.L. 101-508, §11332(a)(2), struck out a semicolon and substituted ", or".

[304] P.L. 101-508, §11332(a)(3), added subparagraph (F), applicable to service performed after July 1, 1991.

(B) Service performed in the employ of a church or qualified church-controlled organization if such church or organization has in effect an election under section 3121(w) of the Internal Revenue Code of 1954[306], other than service in an unrelated trade or business (within the meaning of section 513(a) of such Code);

(9) Service performed by an individual as an employee or employee representative as defined in section 3231 of the Internal Revenue Code of 1954;

(10) Service performed in the employ of—

(A) a school, college, or university, or

(B) an organization described in section 509(a)(3) of the Internal Revenue Code of 1954 if the organization is organized, and at all times thereafter is operated, exclusively for the benefit of, to perform the functions of, or to carry out the purposes of a school, college, or university and is operated, supervised, or controlled by or in connection with such school, college, or university, unless it is a school, college, or university of a State or a political subdivision thereof and the services in its employ performed by a student referred to in section 218(c)(5) are covered under the agreement between the Secretary and such State entered into pursuant to section 218;

if such service is performed by a student who is enrolled and regularly attending classes at such school, college, or university;

(11) Service performed in the employ of a foreign government (including service as a consular or other officer or employee or a nondiplomatic representative);

(12) Service performed in the employ of an instrumentality wholly owned by a foreign government—

(A) If the service is of a character similar to that performed in foreign countries by employees of the United States Government or of an instrumentality thereof; and

(B) If the Secretary of State shall certify to the Secretary of the Treasury that the foreign government, with respect to whose instrumentality and employees thereof exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States Government and of instrumentalities thereof;

(13) Service performed as a student nurse in the employ of a hospital or a nurses' training school by an individual who is enrolled and is regularly attending classes in a nurses' training school chartered or approved pursuant to State law;

(14)(A) Service performed by an individual under the age of eighteen in the delivery or distribution of newspapers or shopping news, not including delivery or distribution to any point for subsequent delivery or distribution;

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[305] See P.L. 83-591, §3121(r); (this volume).

[306] P.L. 83-591.

(B) Service performed by an individual in, and at the time of, the sale of newspapers or magazines to ultimate consumers, under an arrangement under which the newspapers or magazines are to be sold by him at a fixed price, his compensation being based on the retention of the excess of such price over the amount at which the newspapers or magazines are charged to him, whether or not he is guaranteed a minimum amount of compensation for such service, or is entitled to be credited with the unsold newspapers or magazines turned back;

(15) Service performed in the employ of an international organization entitled to enjoy privileges, exemptions, and immunities as an international organization under the International Organizations Immunities Act[307] (59 Stat. 669);

(16) Service performed by an individual under an arrangement with the owner or tenant of land pursuant to which—

(A) such individual undertakes to produce agricultural or horticultural commodities (including livestock, bees, poultry, and fur-bearing animals and wildlife) on such land,

(B) the agricultural or horticultural commodities produced by such individual, or the proceeds therefrom, are to be divided between such individual and such owner or tenant, and

(C) the amount of such individual's share depends on the amount of the agricultural or horticultural commodities produced;

(17) Service in the employ of any organization which is performed (A) in any year during any part of which such organization is registered, or there is in effect a final order of the Subversive Activities Control Board requiring such organization to register, under the Internal Security Act of 1950[308], as amended, as a Communist-action organization, a Communist-front organization, or a Communist-infiltrated organization, and (B) after June 30, 1956;

(18) Service performed in Guam by a resident of the Republic of the Philippines while in Guam on a temporary basis as a nonimmigrant alien admitted to Guam pursuant to section 101(a)(15)(H)(ii) of the Immigration and Nationality Act[309] (8 U.S.C. 1101(a)(15)(H)(ii));

(19) Service which is performed by a nonresident alien individual for the period he is temporarily present in the United States as a nonimmigrant under subparagraph (F), (J), or (M) of section 101(a)(15) of the Immigration and Nationality Act, as amended, and which is performed to carry out the purpose specified in subparagraph (F), (J), or (M), as the case may be; or

(20) Service (other than service described in paragraph (3)(A)) performed by an individual on a boat engaged in catching fish or other forms of aquatic animal life under an arrangement with the owner or operator of such boat pursuant to which—

(A) such individual does not receive any cash remuneration (other than as provided in subparagraph (B)),

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[307] See Vol. II, P.L. 79-291.

[308] P.L. 81-831.

[309] P.L. 82-414.

(B) such individual receives a share of the boat's (or the boats' in the case of a fishing operation involving more than one boat) catch of fish or other forms of aquatic animal life or a share of the proceeds from the sale of such catch, and

(C) the amount of such individual's share depends on the amount of the boat's (or boats' in the case of a fishing operation involving more than one boat) catch of fish or other forms of aquatic animal life,

but only if the operating crew of such boat (or each boat from which the individual receives a share in the case of a fishing operation involving more than one boat) is normally made up of fewer than 10 individuals.

Included and Excluded Service

(b) If the services performed during one-half or more of any pay period by an employee for the person employing him constitute employment, all the services of such employee for such period shall be deemed to be employment; but if the services performed during more than one-half of any such pay period by an employee for the person employing him do not constitute employment, then none of the services of such employee for such period shall be deemed to be employment. As used in this subsection, the term "pay period" means a period (of not more than thirty-one consecutive days) for which a payment of remuneration is ordinarily made to the employee by the person employing him. This subsection shall not be applicable with respect to services performed in a pay period by an employee for the person employing him, where any of such service is excepted by paragraph (9) of subsection (a).

American Vessel

(c) The term "American vessel" means any vessel documented or numbered under the laws of the United States; and includes any vessel which is neither documented or numbered under the laws of the United States nor documented under the laws of any foreign country, if its crew is employed solely by one or more citizens or residents of the United States or corporations organized under the laws of the United States or of any State.

American Aircraft

(d) The term "American aircraft" means an aircraft registered under the laws of the United States.

American Employer

(e) The term "American employer" means an employer which is (1) the United States or any instrumentality thereof, (2) a State or any political subdivision thereof, or any instrumentality of any one or more of the foregoing, (3) an individual who is a resident of the United States, (4) a partnership, if two-thirds or more of the partners are residents of the United States, (5) a trust, if all of the trustees are residents of the United States, or (6) a corporation organized under the laws of the United States or of any State.

Agricultural Labor

(f) The term "agricultural labor" includes all service performed—

(1) On a farm, in the employ of any person, in connection with cultivating the soil, or in connection with raising or harvesting any agricultural or horticultural commodity, including the raising, shearing, feeding, caring for, training, and management of livestock, bees, poultry, and fur-bearing animals and wildlife.

(2) In the employ of the owner or tenant or other operator of a farm, in connection with the operation, management, conservation, improvement, or maintenance of such farm and its tools and equipment, or in salvaging timber or clearing land of brush and other debris left by a hurricane, if the major part of such service is performed on a farm.

(3) In connection with the production or harvesting of any commodity defined as an agricultural commodity in section 15(g) of the Agricultural Marketing Act[310], as amended, or in connection with the ginning of cotton, or in connection with the operation or maintenance of ditches, canals, reservoirs, or waterways, not owned or operated for profit, used exclusively for supplying and storing water for farming purposes.

(4)(A) In the employ of the operator of a farm in handling, planting, drying, packing, packaging, processing, freezing, grading, storing, or delivering to storage or to market or to a carrier for transportation to market, in its unmanufactured state, any agricultural or horticultural commodity; but only if such operator produced more than one-half of the commodity with respect to which such service is performed.

(B) In the employ of a group of operators of farms (other than a cooperative organization) in the performance of service described in subparagraph (A), but only if such operators produced all of the commodity with respect to which such service is performed. For the purposes of this subparagraph, any unincorporated group of operators shall be deemed a cooperative organization if the number of operators comprising such group is more than twenty at any time during the calendar year in which such service is performed.

(5) On a farm operated for profit if such service is not in the course of the employer's trade or business or is domestic service in a private home of the employer.

The provisions of subparagraphs (A) and (B) of paragraph (4) shall not be deemed to be applicable with respect to service performed in connection with commercial canning or commercial freezing or in connection with any agricultural or horticultural commodity after its delivery to a terminal market for distribution for consumption.

Farm

(g) The term "farm" includes stock, dairy, poultry, fruit, fur-bearing animal, and truck farms, plantations, ranches, nurseries, ranges, greenhouses or other similar structures used primarily for the raising of agricultural or horticultural commodities, and orchards.

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[310] P.L. 71-10.

State

(h) The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

United States

(i) The term "United States" when used in a geographical sense means the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

Employee

(j) The term "employee" means—

(1) any officer of a corporation; or

(2) any individual who, under the usual common law rules applicable in determining the employer-employee relationship, has the status of an employee; or

(3) any individual (other than an individual who is an employee under paragraph (1) or (2) of this subsection) who performs services for remuneration for any person—

(A) as an agent-driver or commission-driver engaged in distributing meat products, vegetable products, fruit products, bakery products, beverages (other than milk), or laundry or dry-cleaning services, for his principal;

(B) as a full-time life insurance salesman;

(C) as a home worker performing work, according to specifications furnished by the person for whom the services are performed, on materials or goods furnished by such person which are required to be returned to such person or a person designated by him; or

(D) as a traveling or city salesman, other than as an agent-driver or commission-driver, engaged upon a full-time basis in the solicitation on behalf of, and the transmission to, his principal (except for side-line sales activities on behalf of some other person) of orders from wholesalers, retailers, contractors, or operators of hotels, restaurants, or other similar establishments for merchandise for resale or supplies for use in their business operations;

if the contract of service contemplates that substantially all of such services are to be performed personally by such individual; except that an individual shall not be included in the term "employee" under the provisions of this paragraph if such individual has a substantial investment in facilities used in connection with the performance of such services (other than in facilities for transportation), or if the services are in the nature of a single transaction not part of a continuing relationship with the person for whom the services are performed.

Covered Transportation Service

(k)(1) Except as provided in paragraph (2), all service performed in the employ of a State or political subdivision in connection with its operation of a public transportation system shall constitute covered transportation service if any part of the transportation system was acquired from private ownership after 1936 and prior to 1951.

(2) Service performed in the employ of a State or political subdivision in connection with the operation of its public transportation system shall not constitute covered transportation service if—

(A) any part of the transportation system was acquired from private ownership after 1936 and prior to 1951, and substantially all service in connection with the operation of the transportation system is, on December 31, 1950, covered under a general retirement system providing benefits which, by reason of a provision of the State constitution dealing specifically with retirement systems of the State or political subdivisions thereof, cannot be diminished or impaired; or

(B) no part of the transportation system operated by the State or political subdivision on December 31, 1950, was acquired from private ownership after 1936 and prior to 1951;

except that if such State or political subdivision makes an acquisition after 1950 from private ownership of any part of its transportation system, then, in the case of any employee who—

(C) became an employee of such State or political subdivision in connection with and at the time of its acquisition after 1950 of such part, and

(D) prior to such acquisition rendered service in employment in connection with the operation of such part of the transportation system acquired by the State or political subdivision,

the service of such employee in connection with the operation of the transportation system shall constitute covered transportation service, commencing with the first day of the third calendar quarter following the calendar quarter in which the acquisition of such part took place, unless on such first day such service of such employee is covered by a general retirement system which does not, with respect to such employee, contain special provisions applicable only to employees described in subparagraph (C).

(3) All service performed in the employ of a State or political subdivision thereof in connection with its operation of a public transportation system shall constitute covered transportation service if the transportation system was not operated by the State or political subdivision prior to 1951 and, at the time of its first acquisition (after 1950) from private ownership of any part of its transportation system, the State or political subdivision did not have a general retirement system covering substantially all service performed in connection with the operation of the transportation system.

(4) For the purposes of this subsection—

(A) The term "general retirement system" means any pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof for employees of the State, political subdivision, or both; but such term shall not include such a fund or system which covers only service performed in positions connected with the operation of its public transportation system.

(B) A transportation system or a part thereof shall be considered to have been acquired by a State or political subdivision from private ownership if prior to the acquisition service performed by employees in connection with the operation of the system or part thereof acquired constituted employment under this title, and some of such employees became employees of the State or political subdivision in connection with and at the time of such acquisition.

(C) The term "political subdivision" includes an instrumentality of (i) a State, (ii) one or more political subdivisions of a State, or (iii) a State and one or more of its political subdivisions.

Service in the Uniformed Services

(l)(1) Except as provided in paragraph (4), the term "employment" shall, notwithstanding the provisions of subsection (a) of this section, include —

(A) service performed after December 1956 by an individual as a member of a uniformed service on active duty, but such term shall not include any such service which is performed while on leave without pay, and

(B) service performed after December 1987 by an individual as a member of a uniformed service on inactive duty training.

(2) The term "active duty" means "active duty" as described in paragraph (21) of section 101 of title 38, United States Code, except that it shall also include "active duty for training" as described in paragraph (22) of such section.

(3) The term "inactive duty training" means "inactive duty training" as described in paragraph (23) of such section 101.

(4)(A) Paragraph (1) of this subsection shall not apply in the case of any service, performed by an individual as a member of a uniformed service, which is creditable under section 3(i) of the Railroad Retirement Act of 1974[311]. The Railroad Retirement Board shall notify the Secretary, with respect to all such service which is so creditable.

(B) In any case where benefits under this title are already payable on the basis of such individual's wages and self-employment income at the time such notification (with respect to such individual) is received by the Secretary, the Secretary shall certify no further benefits for payment under this title on the basis of such individual's wages and self-employment income, or shall recompute the amount of any further benefits payable on the basis of such wages and self-employment income, as may be required as a consequence of subparagraph (A) of this paragraph. No payment of a benefit to any person on the basis of such individual's wages and self-employment income, certified by the Secretary prior to the end of the month in which he receives such notification from the Railroad Retirement Board, shall be deemed by reason of this subparagraph to have been an erroneous payment or a payment to which such person was not entitled. The Secretary shall, as soon as possible after the receipt of such notification from the Railroad Retirement Board, advise such Board whether or not any such benefit will be reduced or terminated by reason of subparagraph (A), and if any such benefit will be so reduced or terminated, specify the first month with respect to which such reduction or termination will be effective.

Member of a Uniformed Service[312]

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[311] P.L. 75-162 [as amended by P.L. 93-445].

[312] See Vol. II, P.L. 95-202, §401, with respect to the WW II military status of the Women's Air Forces Service Pilots.

(m) The term "member of a uniformed service" means any person appointed, enlisted, or inducted in a component of the Army, Navy, Air Force, Marine Corps, or Coast Guard (including a reserve component as defined in section 101(27) of title 38, United States Code), or in one of those services without specification of component, or as a commissioned officer of the Coast and Geodetic Survey, the National Oceanic and Atmospheric Administration Corps, or the Regular or Reserve Corps of the Public Health Service, and any person serving in the Army or Air Force under call or conscription. The term includes—

(1) a retired member of any of those services;

(2) a member of the Fleet Reserve or Fleet Marine Corps Reserve;

(3) a cadet at the United States Military Academy, a midshipman at the United States Naval Academy, and a cadet at the United States Coast Guard Academy or United States Air Force Academy;

(4) a member of the Reserve Officers' Training Corps, the Naval Reserve Officers' Training Corps, or the Air Force Reserve Officers' Training Corps, when ordered to annual training duty for fourteen days or more, and while performing authorized travel to and from that duty; and

(5) any person while en route to or from, or at, a place for final acceptance or for entry upon active duty in the military, naval, or air service—

(A) who has been provisionally accepted for such duty; or

(B) who, under the Military Selective Service Act, has been selected for active military, naval, or air service;

and has been ordered or directed to proceed to such place.

The term does not include a temporary member of the Coast Guard Reserve.

Crew Leader

(n) The term "crew leader" means an individual who furnishes individuals to perform agricultural labor for another person, if such individual pays (either on his own behalf or on behalf of such person) the individuals so furnished by him for the agricultural labor performed by them and if such individual has not entered into a written agreement with such person whereby such individual has been designated as an employee of such person; and such individuals furnished by the crew leader to perform agricultural labor for another person shall be deemed to be the employees of such crew leader. A crew leader shall, with respect to services performed in furnishing individuals to perform agricultural labor for another person and service performed as a member of the crew, be deemed not to be an employee of such other person.

Peace Corps Volunteer Service

(o) The term "employment" shall, notwithstanding the provisions of subsection (a), include service performed by an individual as a volunteer or volunteer leader within the meaning of the Peace Corps Act[313].

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[313] P.L. 87-293.

Medicare Qualified Government Employment

(p)(1) For purposes of sections 226 and 226A, the term "medicare qualified government employment" means any service which would constitute "employment" as defined in subsection (a) of this section but for the application of the provisions of—

(A) subsection (a)(5), or

(B) subsection (a)(7), except as provided in paragraphs (2) and (3).

(2) Service shall not be treated as employment by reason of paragraph (1)(B) if the service is performed—

(A) by an individual who is employed by a State or political subdivision thereof to relieve him from unemployment,

(B) in a hospital, home, or other institution by a patient or inmate thereof as an employee of a State or political subdivision thereof or of the District of Columbia,

(C) by an individual, as an employee of a State or political subdivision thereof or of the District of Columbia, serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency,

(D) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or a medical or dental resident in training, or

(E) by an election official or election worker if the remuneration paid in a calendar year for such service is less than $100.

As used in this paragraph, the terms "State" and "political subdivision" have the meanings given those terms in section 218(b).

(3) Service performed for an employer shall not be treated as employment by reason of paragraph (1)(B) if—

(A) such service would be excluded from the term "employment" for purposes of this section if paragraph (1)(B) did not apply;

(B) such service is performed by an individual—

(i) who was performing substantial and regular service for remuneration for that employer before April 1, 1986,

(ii) who is a bona fide employee of that employer on March 31, 1986, and

(iii) whose employment relationship with that employer was not entered into for purposes of meeting the requirements of this subparagraph; and

(C) the employment relationship with that employer has not been terminated after March 31, 1986.

(4) For purposes of paragraph (3), under regulations (consistent with regulations established under section 3121(u)(2)(D) of the Internal Revenue Code of 1954[314])—

(A) all agencies and instrumentalities of a State (as defined in section 218(b)) or of the District of Columbia shall be treated as a single employer, and

(B) all agencies and instrumentalities of a political subdivision of a State (as so defined) shall be treated as a single employer and shall not be treated as described in subparagraph (A).

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[314] P.L. 83-591.

Treatment of Real Estate Agents and Direct Sellers

(q) Notwithstanding any other provision of this title, the rules of section 3508 of the Internal Revenue Code of 1954[315] shall apply for purposes of this title.

SELF-EMPLOYMENT

SEC. 211. [42 U.S.C. 411] For the purposes of this title—

Net Earnings From Self-Employment

(a) The term "net earnings from self-employment" means the gross income, as computed under subtitle A of the Internal Revenue Code of 1954, derived by an individual from any trade or business carried on by such individual, less the deductions allowed under such subtitle which are attributable to such trade or business, plus his distributive share (whether or not distributed) of the ordinary net income or loss, as computed under section 702(a)(8) of such Code, from any trade or business carried on by a partnership of which he is a member; except that in computing such gross income and deductions and such distributive share of partnership ordinary net income or loss—

(1) There shall be excluded rentals from real estate and from personal property leased with the real estate (including such rentals paid in crop shares), together with the deductions attributable thereto, unless such rentals are received in the course of a trade or business as a real estate dealer; except that the preceding provisions of this paragraph shall not apply to any income derived by the owner or tenant of land if (A) such income is derived under an arrangement, between the owner or tenant and another individual, which provides that such other individual shall produce agricultural or horticultural commodities (including livestock, bees, poultry, and fur-bearing animals and wildlife) on such land, and that there shall be material participation by the owner or tenant (as determined without regard to any activities of an agent of such owner or tenant) in the production or the management of the production of such agricultural or horticultural commodities, and (B) there is material participation by the owner or tenant (as determined without regard to any activities of an agent of such owner or tenant) with respect to any such agricultural or horticultural commodity;

(2) There shall be excluded dividends on any share of stock, and interest on any bond, debenture, note, or certificate, or other evidence of indebtedness, issued with interest coupons or in registered form by any corporation (including one issued by a government or political subdivision thereof), unless such dividends and interest are received in the course of a trade or business as a dealer in stocks or securities;

(3) There shall be excluded any gain or loss (A) which is considered under subtitle A of the Internal Revenue Code of 1954[316] as gain or loss from the sale or exchange of a capital asset, (B) from the cutting of timber, or the disposal of timber, coal, or iron ore, if section 631 of the Internal Revenue Code of

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[315] See P.L. 83-591, §3508; (this volume).

[316] P.L. 83-591.

1954 applies to such gain or loss, or (C) from the sale, exchange, involuntary conversion, or other disposition of property if such property is neither (i) stock in trade or other property of a kind which would properly be includible in inventory if on hand at the close of the taxable year, nor (ii) property held primarily for sale to customers in the ordinary course of the trade or business;

(4) The deduction for net operating losses provided in section 172 of the Internal Revenue Code of 1954 shall not be allowed;

(5)(A) If any of the income derived from a trade or business (other than a trade or business carried on by a partnership) is community income under community property laws applicable to such income, all of the gross income and deductions attributable to such trade or business shall be treated as the gross income and deductions of the husband unless the wife exercises substantially all of the management and control of such trade or business, in which case all of such gross income and deductions shall be treated as the gross income and deductions of the wife;

(B) If any portion of a partner's distributive share of the ordinary net income or loss from a trade or business carried on by a partnership is community income or loss under the community property laws applicable to such share, all of such distributive share shall be included in computing the net earnings from self-employment of such partner, and no part of such share shall be taken into account in computing the net earnings from self-employment of the spouse of such partner;

(6) A resident of the Commonwealth of Puerto Rico shall compute his net earnings from self-employment in the same manner as a citizen of the United States but without regard to the provisions of section 933 of the Internal Revenue Code of 1954;

(7) An individual who is a duly ordained, commissioned, or licensed minister of a church or a member of a religious order shall compute his net earnings from self-employment derived from the performance of service described in subsection (c)(4) without regard to section 107 (relating to rental value of parsonages), section 119 (relating to meals and lodging furnished for the convenience of the employer), and section 911 (relating to earned income from sources without the United States) of the Internal Revenue Code of 1986;

(8) The exclusion from gross income provided by section 931 of the Internal Revenue Code of 1986 shall not apply;

(9) There shall be excluded amounts received by a partner pursuant to a written plan of the partnership, which meets such requirements as are prescribed by the Secretary of the Treasury or his delegate, and which provides for payments on account of retirement, on a periodic basis, to partners generally or to a class or classes of partners, such payments to continue at least until such partner's death, if—

(A) such partner rendered no services with respect to any trade or business carried on by such partnership (or its successors) during the taxable year of such partnership (or its successors), ending within or with his taxable year, in which such amounts were received, and

(B) no obligation exists (as of the close of the partnership's taxable year referred to in subparagraph (A)) from the other partners to such partner except with respect to retirement payments under such plan, and

(C) such partner's share, if any, of the capital of the partnership has been paid to him in full before the close of the partnership's taxable year referred to in subparagraph (A);

(10) The exclusion from gross income provided by section 911(a)(1) of the Internal Revenue Code of 1954[317] shall not apply;

(11) In lieu of the deduction provided by section 164(f) of the Internal Revenue Code of 1954 (relating to deduction for one-half of self-employment taxes), there shall be allowed a deduction equal to the product of—

(A) the taxpayer's net earnings from self-employment for the taxable year (determined without regard to this paragraph), and

(B) one-half of the sum of the rates imposed by subsections (a) and (b) of section 1401 of such Code[318] for such year;[319]

(12)[320] There shall be excluded the distributive share of any item of income or loss of a limited partner, as such, other than guaranteed payments described in section 707(c) of the Internal Revenue Code of 1954[321] to that partner for services actually rendered to or on behalf of the partnership to the extent that those payments are established to be in the nature of remuneration for those services;

(13) In the case of church employee income, the special rules of subsection (i)(1) shall apply; and

(14) There shall be excluded income excluded from taxation under section 7873 of the Internal Revenue Code of 1986 (relating to income derived by Indians from exercise of fishing rights).

(15)[322] The deduction under section 162(m) (relating to health insurance costs of self-employed individuals) shall not be allowed.

If the taxable year of a partner is different from that of the partnership, the distributive share which he is required to include in computing his net earnings from self-employment shall be based upon the ordinary net income or loss of the partnership for any taxable year of the partnership (even though beginning prior to 1951) ending within or with his taxable year. In the case of any trade or business which is carried on by an individual or by a partnership and in which, if such trade or business were carried on exclusively by employees, the major portion of the services would constitute agricultural labor as defined in section 210(f)—

(i) in the case of an individual, if the gross income derived by him from such trade or business is not more than $2,400, the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be 66 2/3 percent of such gross income; or

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[317] P.L. 83-591.

[318] See P.L. 83-591, §1401; (this volume).

[319] P.L. 98-21, §124(c)(3), inserted this paragraph (11), effective with respect to taxable years beginning after December 31, 1989.

[320] P.L. 98-21, §124(c)(3), redesignated paragraph (11) as paragraph (12), effective with respect to taxable years beginning after December 31, 1989.

[321] P.L. 83-591.

[322] P.L. 101-508, §5130(a)(3), redesignated this paragraph as paragraph (15), effective as if included in the enactment of P.L. 100-647.

(ii) in the case of an individual, if the gross income derived by him from such trade or business is more than $2,400 and the net earnings from self-employment derived by him from such trade or business (computed under this subsection without regard to this sentence) are less than $1,600, the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be $1,600; and

(iii) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the sum of all payments to which section 707(c) of the Internal Revenue Code of 1954 applies) is not more than $2,400, his distributive share of income described in section 702(a)(8) of such Code derived from such trade or business may, at his option, be deemed to be an amount equal to 66 2/3 percent of his distributive share of such gross income (after such gross income has been so reduced); or

(iv) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the sum of all payments to which section 707(c) of the Internal Revenue Code of 1954 applies) is more than $2,400 and his distributive share (whether or not distributed) of income described in section 702(a)(8) of such Code derived from such trade or business (computed under this subsection without regard to this sentence) is less than $1,600, his distributive share of income described in such section 702(a)(8) derived from such trade or business may, at his option, be deemed to be $1,600.

For purposes of the preceding sentence, gross income means—

(v) in the case of any such trade or business in which the income is computed under a cash receipts and disbursements method, the gross receipts from such trade or business reduced by the cost or other basis of property which was purchased and sold in carrying on such trade or business, adjusted (after such reduction) in accordance with the provisions of paragraphs (1) through (6) and paragraph (8) of this subsection; and

(vi) in the case of any such trade or business in which the income is computed under an accrual method, the gross income from such trade or business, adjusted in accordance with the provisions of paragraphs (1) through (6) and paragraph (8) of this subsection;

and, for purposes of such sentence, if an individual (including a member of a partnership) derives gross income from more than one such trade or business, such gross income (including his distributive share of the gross income of any partnership derived from any such trade or business) shall be deemed to have been derived from one trade or business.

The preceding sentence and clauses (i) through (iv) of the second preceding sentence shall also apply in the case of any trade or business (other than a trade or business specified in such second preceding sentence) which is carried on by an individual who is self-employed on a regular basis as defined in subsection (g), or by a partnership of which an individual is a member on a regular basis as defined in subsection (g), but only if such individual's net earnings from self-employment in the taxable year as determined without regard to this sentence are less than $1,600 and less than 66 2/3 percent of the sum (in such taxable year) of such individual's gross income derived from all trades or businesses carried on by him and his distributive share of the income or loss from all trades or businesses carried on by all the partnerships of which he is a member; except that this sentence shall not apply to more than 5 taxable years in the case of any individual, and in no case in which an individual elects to determine the amount of his net earnings from self-employment for a taxable year under the provisions of the two preceding sentences with respect to a trade or business to which the second preceding sentence applies and with respect to a trade or business to which this sentence applies shall such net earnings for such year exceed $1,600.[323]

Self-Employment Income[324]

(b) The term "self-employment income" means the net earnings from self-employment derived by an individual (other than a nonresident alien individual, except as provided by an agreement under section 233) during any taxable year beginning after 1950; except that such term shall not include—

(1) That part of the net earnings from self-employment which is in excess of—

(A) For any taxable year ending prior to 1955, (i) $3,600, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(B) For any taxable year ending after 1954 and prior to 1959, (i) $4,200, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(C) For any taxable year ending after 1958 and prior to 1966, (i) $4,800, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(D) For any taxable year ending after 1965 and prior to 1968, (i) $6,600, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(E) For any taxable year ending after 1967 and beginning prior to 1972, (i) $7,800, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(F) For any taxable year beginning after 1971 and prior to 1973, (i) $9,000, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(G) For any taxable year beginning after 1972 and prior to 1974, (i) $10,800, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(H) For any taxable year beginning after 1973 and prior to 1975, (i) $13,200, minus (ii) the amount of the wages paid to such individual during the taxable year; and

(I) For any taxable year beginning in any calendar year after 1974, (i) an amount equal to the contribution and benefit base (as determined under section 230) which is effective for such calendar year, minus (ii) the amount of the wages paid to such individual during such taxable year; or

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[323] P.L. 101-508, §5123(a)(1), moved the last undesignated paragraph of §211(a) to §203(f)(5)(E).

[324] See Vol. II, P.L. 98-4, §3(b)(4), with respect to the treatment of agricultural commodities received under a 1983 payment-in-kind program.

(2) The net earnings from self-employment, if such net earnings for the taxable year are less than $400.

An individual who is not a citizen of the United States but who is a resident of the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa shall not, for the purposes of this subsection, be considered to be a nonresident alien individual. In the case of church employee income, the special rules of subsection (i)(2) shall apply for purposes of paragraph (2).

Trade or Business

(c) The term "trade or business", when used with reference to self-employment income or net earnings from self-employment, shall have the same meaning as when used in section 162 of the Internal Revenue Code of 1954[325], except that such term shall not include—

(1) The performance of the functions of a public office, other than the functions of a public office of a State or a political subdivision thereof with respect to fees received in any period in which the functions are performed in a position compensated solely on a fee basis and in which such functions are not covered under an agreement entered into by such State and the Secretary pursuant to section 218;

(2) The performance of service by an individual as an employee, other than—

(A) service described in section 210(a)(14)(B) performed by an individual who has attained the age of eighteen,

(B) service described in section 210(a)(16),

(C) service described in section 210(a)(11), (12), or (15) performed in the United States by a citizen of the United States,

(D) service described in paragraph (4) of this subsection,

(E) service performed by an individual as an employee of a State or a political subdivision thereof in a position compensated solely on a fee basis with respect to fees received in any period in which such service is not covered under an agreement entered into by such State and the Secretary pursuant to section 218,

(F) service described in section 210(a)(20), and

(G) service described in section 210(a)(8)(B);

(3) The performance of service by an individual as an employee or employee representative as defined in section 3231 of the Internal Revenue Code of 1954;

(4) The performance of service by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order;

(5) The performance of service by an individual in the exercise of his profession as a Christian Science practitioner; or

(6) The performance of service by an individual during the period for which an exemption under section 1402(g) of the Internal Revenue Code of 1954[326] is effective with respect to him.

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[325] P.L. 83-591.

[326] P.L. 83-591, §1402(g); (this volume).

The provisions of paragraph (4) or (5) shall not apply to service (other than service performed by a member of a religious order who has taken a vow of poverty as a member of such order) performed by an individual unless an exemption under section 1402(e) of the Internal Revenue Code of 1954[327] is effective with respect to him.

Partnership and Partner

(d) The term "partnership" and the term "partner" shall have the same meaning as when used in subchapter K of chapter 1 of the Internal Revenue Code of 1954[328].

Taxable Year

(e) The term "taxable year" shall have the same meaning as when used in subtitle A of the Internal Revenue Code of 1954; and the taxable year of any individual shall be a calendar year unless he has a different taxable year for the purposes of subtitle A of such Code, in which case his taxable year for the purposes of this title shall be the same as his taxable year under such subtitle A.

Partner's Taxable Year Ending as Result of Death

(f) In computing a partner's net earnings from self-employment for his taxable year which ends as a result of his death (but only if such taxable year ends within, and not with, the taxable year of the partnership), there shall be included so much of the deceased partner's distributive share of the partnership's ordinary income or loss for the partnership taxable year as is not attributable to an interest in the partnership during any period beginning on or after the first day of the first calendar month following the month in which such partner died. For purposes of this subsection—

(1) in determining the portion of the distributive share which is attributable to any period specified in the preceding sentence, the ordinary income or loss of the partnership shall be treated as having been realized or sustained ratably over the partnership taxable year; and

(2) the term "deceased partner's distributive share" includes the share of his estate or of any other person succeeding, by reason of his death, to rights with respect to his partnership interest.

Regular Basis

(g) An individual shall be deemed to be self-employed on a regular basis in a taxable year, or to be a member of a partnership on a regular basis in such year, if he had net earnings from self-employment, as defined in the first sentence of subsection (a), of not less than $400 in at least two of the three consecutive taxable years immediately preceding such taxable year from trades or businesses carried on by such individual or such partnership.

(h)(1) In determining the net earnings from self-employment of any options dealer or commodities dealer—

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[327] See P.L. 83-591, §1402(e); (this volume).

[328] P.L. 83-591.

(A) notwithstanding subsection (a)(3)(A), there shall not be excluded any gain or loss (in the normal course of the taxpayer's activity of dealing in or trading section 1256 contracts) from section 1256 contracts or property related to such contracts, and

(B) the deduction provided by section 1202 of the Internal Revenue Code of 1954 shall not apply.

(2) For purposes of this subsection—

(A) The term "options dealer" has the meaning given such term by section 1256(g)(8) of such Code.

(B) The term "commodities dealer" means a person who is actively engaged in trading section 1256 contracts and is registered with a domestic board of trade which is designated as a contract market by the Commodities Futures Trading Commission.

(C) The term "section 1256 contracts" has the meaning given to such term by section 1256(b) of such Code.

(i)(1) In applying subsection (a)—

(A) church employee income shall not be reduced by any deduction;

(B) church employee income and deductions attributable to such income shall not be taken into account in determining the amount of other net earnings from self-employment.

(2)(A) Subsection (b)(2) shall be applied separately—

(i) to church employee income, and

(ii) to other net earnings from self-employment.

(B) In applying subsection (b)(2) to church employee income, "$100" shall be substituted for "$400".

(3) Paragraph (1) shall not apply to any amount allowable as a deduction under subsection (a)(11), and paragraph (1) shall be applied before determining the amount so allowable.

(4) For purposes of this section, the term "church employee income" means gross income for services which are described in section 210(a)(8)(B) (and are not described in section 210(a)(8)(A)).

CREDITING OF SELF-EMPLOYMENT INCOME TO CALENDAR YEARS

SEC. 212. [42 U.S.C. 412] (a) For the purposes of determining average monthly wage and quarters of coverage the amount of self-employment income derived during any taxable year which begins before 1978 shall—

(1) in the case of a taxable year which is a calendar year, be credited equally to each quarter of such calendar year; and

(2) in the case of any other taxable year, be credited equally to the calendar quarter in which such taxable year ends and to each of the next three or fewer preceding quarters any part of which is in such taxable year.

(b) For the purposes of determining average indexed monthly earnings, average monthly wage, and quarters of coverage the amount of self-employment income derived during any taxable year which begins after 1977 shall—

(1) in the case of a taxable year which is a calendar year or which begins with or during a calendar year and ends with or during such year, be credited to such calendar year; and

(2) in the case of any other taxable year, be allocated proportionately to the two calendar years, portions of which are

included within such taxable year, on the basis of the number of months in each such calendar year which are included completely within the taxable year.

For purposes of clause (2), the calendar month in which a taxable year ends shall be treated as included completely within that taxable year.

QUARTER AND QUARTER OF COVERAGE

Definitions

SEC. 213. [42 U.S.C. 413] (a) For the purposes of this title—

(1) The term "quarter", and the term "calendar quarter", mean a period of three calendar months ending on March 31, June 30, September 30, or December 31.

(2)(A) The term "quarter of coverage" means—

(i) for calendar years before 1978, and subject to the provisions of subparagraph (B), a quarter in which an individual has been paid $50 or more in wages (except wages for agricultural labor paid after 1954) or for which he has been credited (as determined under section 212) with $100 or more of self-employment income; and

(ii) for calendar years after 1977, and subject to the provisions of subparagraph (B), each portion of the total of the wages paid and the self-employment income credited (pursuant to section 212) to an individual in a calendar year which equals the amount required for a quarter of coverage in that calendar year (as determined under subsection (d)), with such quarter of coverage being assigned to a specific calendar quarter in such calendar year only if necessary in the case of any individual who has attained age 62 or died or is under a disability and the requirements for insured status in subsection (a) or (b) of section 214, the requirements for entitlement to a computation or recomputation of his primary insurance amount, or the requirements of paragraph (3) of section 216(i) would not otherwise be met.

(B) Notwithstanding the provisions of subparagraph (A)—

(i) no quarter after the quarter in which an individual dies shall be a quarter of coverage, and no quarter any part of which is included in a period of disability (other than the initial quarter and the last quarter of such period) shall be a quarter of coverage;

(ii) if the wages paid to an individual in any calendar year equal $3,000 in the case of a calendar year before 1951, or $3,600 in the case of a calendar year after 1950 and before 1955, or $4,200 in the case of a calendar year after 1954 and before 1959, or $4,800 in the case of a calendar year after 1958 and before 1966, or $6,600 in the case of a calendar year after 1965 and before 1968, or $7,800 in the case of a calendar year after 1967 and before 1972, or $9,000 in the case of the calendar year 1972, or $10,800 in the case of the calendar year 1973, or $13,200 in the case of the calendar year 1974, or an amount equal to the contribution and benefit base (as determined under section 230) in the case of any calendar year after 1974 and before 1978 with respect to which such contribution and benefit base is effective, each quarter of such year shall (subject to clauses (i) and (v)) be a quarter of coverage;

(iii) if an individual has self-employment income for a taxable year, and if the sum of such income and the wages paid to him during such year equals $3,600 in the case of a taxable year beginning after 1950 and ending before 1955, or $4,200 in the case of a taxable year ending after 1954 and before 1959, or $4,800 in the case of a taxable year ending after 1958 and before 1966, or $6,600 in the case of a taxable year ending after 1965 and before 1968, or $7,800 in the case of a taxable year ending after 1967 and before 1972, or $9,000 in the case of a taxable year beginning after 1971 and before 1973, or $10,800 in the case of a taxable year beginning after 1972 and before 1974, or $13,200 in the case of a taxable year beginning after 1973 and before 1975, or an amount equal to the contribution and benefit base (as determined under section 230) which is effective for the calendar year in the case of any taxable year beginning in any calendar year after 1974 and before 1978, each quarter any part of which falls in such year shall (subject to clauses (i) and (v)) be a quarter of coverage;

(iv) if an individual is paid wages for agricultural labor in a calendar year after 1954 and before 1978, then, subject to clauses (i) and (v), (I) the last quarter of such year which can be but is not otherwise a quarter of coverage shall be a quarter of coverage if such wages equal or exceed $100 but are less than $200; (II) the last two quarters of such year which can be but are not otherwise quarters of coverage shall be quarters of coverage if such wages equal or exceed $200 but are less than $300; (III) the last three quarters of such year which can be but are not otherwise quarters of coverage shall be quarters of coverage if such wages equal or exceed $300 but are less than $400; and (IV) each quarter of such year which is not otherwise a quarter of coverage shall be a quarter of coverage if such wages are $400 or more;

(v) no quarter shall be counted as a quarter of coverage prior to the beginning of such quarter;

(vi) not more than one quarter of coverage may be credited to a calendar quarter; and

(vii) no more than four quarters of coverage may be credited to any calendar year after 1977.

If in the case of an individual who has attained age 62 or died or is under a disability and who has been paid wages for agricultural labor in a calendar year after 1954 and before 1978, the requirements for insured status in subsection (a) or (b) of section 214, the requirements for entitlement to a computation or recomputation of his primary insurance amount, or the requirements of paragraph (3) of section 216(i) are not met after assignment of quarters of coverage to quarters in such year as provided in clause (iv) of the preceding sentence, but would be met if such quarters of coverage were assigned to different quarters in such year, then such quarters of coverage shall instead be assigned, for purposes only of determining compliance with such requirements, to such different quarters. If, in the case of an individual who did not die prior to January 1, 1955, and who attained age 62 (if a woman) or age 65 (if a man) or died before July 1, 1957, the requirements for insured status in section 214(a)(3) are not met because of his having too few quarters of coverage but would be met if his quarters of coverage in the first calendar year in which he had any covered employment had been determined on the basis of the period during which wages were earned rather than on the basis of the period during which wages were paid (any such wages paid that are reallocated on an earned basis shall not be used in determining quarters of coverage for subsequent calendar years), then upon application filed by the individual or his survivors and satisfactory proof of his record of wages earned being furnished by such individual or his survivors, the quarters of coverage in such calendar year may be determined on the basis of the periods during which wages were earned.

Crediting of Wages Paid in 1937

(b) With respect to wages paid to an individual in the six-month periods commencing either January 1, 1937, or July 1, 1937; (A) if wages of not less than $100 were paid in any such period, one-half of the total amount thereof shall be deemed to have been paid in each of the calendar quarters in such period; and (B) if wages of less than $100 were paid in any such period, the total amount thereof shall be deemed to have been paid in the latter quarter of such period, except that if in any such period, the individual attained age sixty-five, all of the wages paid in such period shall be deemed to have been paid before such age was attained.

Alternative Method for Determining Quarters of Coverage With Respect to Wages in the Period from 1937 to 1950[329]

(c) For purposes of section 214(a) and 215(d)[330], an individual shall be deemed to have one quarter of coverage for each $400 of his total wages prior to 1951 (as defined in section 215(d)(1)(C)), except where such individual is not a fully insured individual on the basis of the number of quarters of coverage so derived plus the number of quarters of coverage derived from the wages and self-employment income credited to such individual for periods after 1950.[331]

Amount Required for a Quarter of Coverage[332]

(d)(1) The amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage in any year under subsection (a)(2)(A)(ii) shall be $250 in the calendar year 1978 and the amount determined under paragraph (2) of this subsection for years after 1978.

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[329] P.L. 90-248, §155(b)(2) [as amended by P.L. 101-508, §5117(c)(2)], provides that this subsection as it formerly read applies only in the case of an individual who applies for benefits under §202(a) after January 2, 1968, or who dies without being entitled to benefits under §202(a) or §223.

As it now reads, it applies to individuals who (A) make application for benefits under section 202 after the 18-month period following November 1990, and (B) are not entitled to benefits under section 227 or 228 for the month in which such application is made.

[330] P.L. 101-508, §5117(c)(1)(A), inserted "and 215(d)".

[331] P.L. 101-508, §5117(c)(1)(B), struck out "except where—" and paragraphs (1) and (2) and substituted "except where such individual is not a fully insured individual on the basis of the number of quarters of coverage so derived plus the number of quarters of coverage derived from the wages and self-employment income credited to such individual for periods after 1950.". For the effective date, see Vol. II, P.L. 101-508, §5117(c)(3). [For paragraphs (1) and (2) as they formerly read, see Vol. III, P.L. 101-508.]

[332] The quarter of coverage amount for 1990 is $520 (54 FR 45801; Oct. 31, 1989), and for 1991 is $540 (55 FR 45856; Oct. 31, 1990).

(2) The Secretary shall, on or before November 1 of 1978 and of every year thereafter, determine and publish in the Federal Register the amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage in the succeeding calendar year. The amount required for a quarter of coverage shall be the larger of—

(A) the amount in effect in the calendar year in which the determination under this subsection is made, or

(B) the product of the amount prescribed in paragraph (1) which is required for a quarter of coverage in 1978 and the ratio of the deemed average total wages (as defined in section 209(k)(1))[333] for the calendar year before the year in which the determination under this paragraph is made to the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1))[334] reported to the Secretary of the Treasury or his delegate for 1976 (as published in the Federal Register in accordance with section 215(a)(1)(D)),

with such product, if not a multiple of $10, being rounded to the next higher multiple of $10 where such amount is a multiple of $5 but not of $10 and to the nearest multiple of $10 in any other case.

INSURED STATUS FOR PURPOSES OF OLD-AGE AND SURVIVORS INSURANCE BENEFITS

SEC. 214. [42 U.S.C. 414] For the purposes of this title—

Fully Insured Individual

(a) The term "fully insured individual" means any individual who had not less than—

(1) one quarter of coverage (whenever acquired) for each calendar year elapsing after 1950 (or, if later, the year in which he attained age 21) and before the year in which he died or (if earlier) the year in which he attained age 62, except that in no case shall an individual be a fully insured individual unless he has at least 6 quarters of coverage; or

(2) 40 quarters of coverage; or

(3) in the case of an individual who died before 1951, 6 quarters of coverage;

not counting as an elapsed year for purposes of paragraph (1) any year any part of which was included in a period of disability (as defined in section 216(i)).

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[333] P.L. 101-239, §10208(b)(2)(A), struck out "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1)[*]) reported to the Secretary of the Treasury or his delegate" and substituted "the deemed average total wages (as defined in section 209(k)(1))", applicable with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

[*] P.L. 101-239, §10208(d)(2)(A)(i), struck out "209(a)" and substituted "209(a)(1)", effective December 19, 1989.

[334] P.L. 101-239, §10208(b)(2)(B), struck out "(as so defined and computed)" and substituted "(as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1))", applicable with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

Currently Insured Individual

(b) The term "currently insured individual" means any individual who had not less than six quarters of coverage during the thirteen-quarter period ending with (1) the quarter in which he died, (2) the quarter in which he became entitled to old-age insurance benefits, (3) the quarter in which he became entitled to primary insurance benefits under this title as in effect prior to the enactment of this section[335], or (4) in the case of any individual entitled to disability insurance benefits, the quarter in which he most recently became entitled to disability insurance benefits, not counting as part of such thirteen-quarter period any quarter any part of which was included in a period of disability unless such quarter was a quarter of coverage.

COMPUTATION OF PRIMARY INSURANCE AMOUNT

SEC. 215. [42 U.S.C. 415] For the purposes of this title—

Primary Insurance Amount

(a)(1)(A) The primary insurance amount of an individual shall (except as otherwise provided in this section) be equal to the sum of—

(i) 90 percent of the individual's average indexed monthly earnings (determined under subsection (b)) to the extent that such earnings do not exceed the amount established for purposes of this clause by subparagraph (B),

(ii) 32 percent of the individual's average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of clause (i) but do not exceed the amount established for purposes of this clause by subparagraph (B), and

(iii) 15 percent of the individual's average indexed monthly earnings to the extent that such earnings exceed the amount established for purposes of clause (ii),

rounded, if not a multiple of $0.10, to the next lower multiple of $0.10, and thereafter increased as provided in subsection (i).

(B)(i) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming eligible for such benefits), in the calendar year 1979, the amount established for purposes of clause (i) and (ii) of subparagraph (A) shall be $180 and $1,085, respectively.

(ii) For individuals who initially become eligible for old-age or disability insurance benefits, or who die (before becoming eligible for such benefits), in any calendar year after 1979, each of the amounts so established shall equal the product of the corresponding amount established with respect to the calendar year 1979 under clause (i) of this subparagraph and the quotient obtained by dividing—

(I) the deemed average total wages (as defined in section 209(k)(1))[336] for the second calendar year preceding the calendar year for which the determination is made, by

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[335] August 28, 1950 [P.L. 81-734, §104(a); 64 Stat. 477, 505].

[336] P.L. 101-239, §10208(b)(2)(A), struck out "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1)[*]) reported to the Secretary of the Treasury or his delegate" and substituted "the deemed average total wages (as defined in section 209(k)(1))", applicable with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

[*] P.L. 101-239, §10208(d)(2)(A)(i), struck out "209(a)" and substituted "209(a)(1)", effective December 19, 1989.

(II) the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1))[337] reported to the Secretary of the Treasury or his delegate for the calendar year 1977.

(iii) Each amount established under clause (ii) for any calendar year shall be rounded to the nearest $1, except that any amount so established which is a multiple of $0.50 but not of $1 shall be rounded to the next higher $1.

(C)(i) No primary insurance amount computed under subparagraph (A) may be less than an amount equal to $11.50 multiplied by the individual's years of coverage in excess of 10, or the increased amount determined for purposes of this clause under subsection (i).

(ii) For purposes of clause (i), the term "years of coverage" with respect to any individual means the number (not exceeding 30) equal to the sum of (I) the number (not exceeding 14 and disregarding any fraction) determined by dividing (a) the total of the wages credited to such individual (including wages deemed to be paid prior to 1951 to such individual under section 217, compensation under the Railroad Retirement Act of 1937[338] prior to 1951 which is creditable to such individual pursuant to this title, and wages deemed to be paid prior to 1951 to such individual under section 231) for years after 1936 and before 1951 by (b) $900, plus (II) the number equal to the number of years after 1950 each of which is a computation base year (within the meaning of subsection (b)(2)(B)(ii)) and in each of which he is credited with wages (including wages deemed to be paid to such individual under section 217, compensation under the Railroad Retirement Act of 1937 or 1974[339] which is creditable to such individual pursuant to this title, and wages deemed to be paid to such individual under section 229) and self-employment income of not less than 25 percent (in the case of a year after 1950 and before 1978) of the maximum amount which (pursuant to subsection (e)) may be counted for such year, or 25 percent (in the case of a year after 1977 and before 1991) or 15 percent (in the case of a year after 1990) of the maximum amount which (pursuant to subsection (e)) could be counted for such year[340] if section 230 as in effect immediately prior to the enactment of the Social Security Amendments of 1977[341] had remained in effect without change (except that, for purposes of subsection (b)(2)(A) of such section 230 as so in effect, the reference therein to the average of the wages of all employees as reported to the Secretary of the Treasury for any calendar year shall be deemed a reference to the deemed average total wages (within the meaning of section 209(k)(1)) for such calendar year).[342]

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[337] P.L. 101-239, §10208(b)(2)(B), struck out "(as so defined and computed)" and substituted "(as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1))", applicable with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

[338] P.L. 75-162.

[339] P.L. 75-162 [as amended by P.L. 93-445].

[340] P.L. 101-508, §5122(a), struck out "of not less than 25 percent of the maximum amount which, pursuant to subsection (e), may be counted for such year, or of not less than 25 percent of the maximum amount which could be so counted for such year (in the case of a year after 1977)", and substituted "of not less than 25 percent (in the case of a year after 1950 and before 1978) of the maximum amount which (pursuant to subsection (e)) may be counted for such year, or 25 percent (in the case of a year after 1977 and before 1991) or 15 percent (in the case of a year after 1990) of the maximum amount which (pursuant to subsection (e)) could be counted for such year", effective November 5, 1990.

[341] December 20, 1977 [P.L. 95-216, 91 Stat. 1509].

(D) In each calendar year after 1978 the Secretary shall publish in the Federal Register, on or before November 1, the formula for computing benefits under this paragraph and for adjusting wages and self-employment income under subsection (b)(3) in the case of an individual who becomes eligible for an old-age insurance benefit, or (if earlier) becomes eligible for a disability insurance benefit or dies, in the following year, and the average of the total wages (as described in subparagraph (B)(ii)(I))[343] on which that formula is based. With the initial publication required by this subparagraph, the Secretary shall also publish in the Federal Register the average of the total wages (as so described) for each calendar year after 1950.

(2)(A) A year shall not be counted as the year of an individual's death or eligibility for purposes of this subsection or subsection (i) in any case where such individual was entitled to a disability insurance benefit for any of the 12 months immediately preceding the month of such death or eligibility (but there shall be counted instead the year of the individual's eligibility for the disability insurance benefit or benefits to which he was entitled during such 12 months).

(B) In the case of an individual who was entitled to a disability insurance benefit for any of the 12 months before the month in which he became entitled to an old-age insurance benefit, became reentitled to a disability insurance benefit, or died, the primary insurance amount for determining any benefit attributable to that entitlement, reentitlement, or death is the greater of—

(i) the primary insurance amount upon which such disability insurance benefit was based, increased by the amount of each general benefit increase (as defined in subsection (i)(3)), and each increase provided under subsection (i)(2), that would have applied to such primary insurance amount had the individual remained entitled to such disability insurance benefit until the month in which he became so entitled or reentitled or died, or

(ii) the amount computed under paragraph (1)(C).

(C) In the case of an individual who was entitled to a disability insurance benefit for any month, and with respect to whom a primary insurance amount is required to be computed at any time after the close of the period of the individual's disability (whether because of such individual's subsequent entitlement to old-age insurance benefits or to a disability insurance benefit based upon a subsequent period of disability, or because of such individual's death), the primary insurance amount so computed may in no case be less than the primary insurance amount with respect to which such former disability insurance benefit was most recently determined.

(3)(A) Paragraph (1) applies only to an individual who was not eligible for an old-age insurance benefit prior to January 1979 and who in that or any succeeding month—

(i) becomes eligible for such a benefit,

(ii) becomes eligible for a disability insurance benefit, or

(iii) dies,

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[342] P.L. 101-239, §10208(b)(4), struck out the period and inserted "(except that, for purposes of subsection (b)(2)(A) of such section 230 as so in effect, the reference therein to the average of the wages of all employees as reported to the Secretary of the Treasury for any calendar year shall be deemed a reference to the deemed average total wages (within the meaning of section 209(k)(1)) for such calendar year).", applicable with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

[343] For 1989, $20,099.55 (55 FR 45856; October 31, 1990).

and (except for subparagraph (C)(i) thereof) it applies to every such individual except to the extent otherwise provided by paragraph (4).

(B) For purposes of this title, an individual is deemed to be eligible—

(i) for old-age insurance benefits, for months beginning with the month in which he attains age 62, or

(ii) for disability insurance benefits, for months beginning with the month in which his period of disability began as provided under section 216(i)(2)(C),

except as provided in paragraph (2)(A) in cases where fewer than 12 months have elapsed since the termination of a prior period of disability.

(4) Paragraph (1) (except for subparagraph (C)(i) thereof) does not apply to the computation or recomputation of a primary insurance amount for—

(A) an individual who was eligible for a disability insurance benefit for a month prior to January 1979 unless, prior to the month in which occurs the event described in clause (i), (ii), or (iii) of paragraph (3)(A), there occurs a period of at least 12 consecutive months for which he was not entitled to a disability insurance benefit, or

(B) an individual who had wages or self-employment income credited for one or more years prior to 1979, and who was not eligible for an old-age or disability insurance benefit, and did not die, prior to January 1979, if in the year for which the computation or recomputation would be made the individual's primary insurance amount would be greater if computed or recomputed—

(i) under section 215(a) as in effect in December 1978, for purposes of old-age insurance benefits in the case of an individual who becomes eligible for such benefits prior to 1984, or

(ii) as provided by section 215(d), in the case of an individual to whom such section applies.

In determining whether an individual's primary insurance amount would be greater if computed or recomputed as provided in subparagraph (B), (I) the table of benefits in effect in December 1978, as modified by paragraph (6), shall be applied without regard to any increases in that table which may become effective (in accordance with subsection (i)(4)) for years after 1978 (subject to clause (iii) of subsection (i)(2)(A)) and (II) such individual's average monthly wage shall be computed as provided by subsection (b)(4).

(5)(A) Subject to subparagraphs (B), (C), (D) and (E), for[344] purposes of computing the primary insurance amount (after December 1978) of an individual to whom paragraph (1) does not apply (other than an individual described in paragraph (4)(B)), this section as in effect in December 1978 shall remain in effect, except that, effective for

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[344] P.L. 101-508, §5117(a)(1)(A), struck out "For" and substituted "(A) Subject to subparagraphs (B), (C), (D) and (E), for", applicable to the computation of the primary insurance amount of any insured individual in any case in which a person becomes entitled to benefits under section 202 or 223 on the basis of such insured individual's wages and self-employment income for months after the 18-month period following the month in which P.L 101-508 was enacted, except that such amendment shall not apply if any person is entitled to benefits based on the wages and self-employment income of such insured individual for the month preceding the initial month of such person's entitlement to such benefits under section 202 or 223.

January 1979, the dollar amount specified in paragraph (3) of subsection (a) shall be increased to $11.50.[345]

(B)(i) Subject to clauses (ii), (iii), and (iv), and notwithstanding any other provision of law, the primary insurance amount of any individual described in subparagraph (C) shall be, in lieu of the primary insurance amount as computed pursuant to any of the provisions referred to in subparagraph (D), the primary insurance amount computed under subsection (a) of section 215 as in effect in December 1978, without regard to subsection (b)(4) and (c) of such section as so in effect.

(ii) The computation of a primary insurance amount under this subparagraph shall be subject to section 104(j)(2) of the Social Security Amendments of 1972 (relating to the number of elapsed years under section 215(b)).

(iii) In computing a primary insurance amount under this subparagraph, the dollar amount specified in paragraph (3) of section 215(a) (as in effect in December 1978) shall be increased to $11.50.

(iv) In the case of an individual to whom section 215(d) applies, the primary insurance amount of such individual shall be the greater of—

(I) the primary insurance amount computed under the preceding clauses of this subparagraph, or

(II) the primary insurance amount computed under section 215(d).[346]

(C) An individual is described in this subparagraph if—

(i) paragraph (1) does not apply to such individual by reason of such individual's eligibility for an old-age or disability insurance benefit, or the individual's death, prior to 1979, and

(ii) such individual's primary insurance amount computed under this section as in effect immediately before the date of the enactment of the Omnibus Budget Reconciliation Act of 1990 would have been computed under the provisions described in subparagraph (D).[347]

(D) The provisions described in this subparagraph are—

(i) the provisions of this subsection as in effect prior to the enactment of the Social Security Amendments of 1965, if such provisions would preclude the use of wages prior to 1951 in the computation of the primary insurance amount,

(ii) the provisions of section 209 as in effect prior to the enactment of the Social Security Act Amendments of 1950, and

(iii) the provisions of section 215(d) as in effect prior to the enactment of the Social Security Amendments of 1977.[348]

(E) For purposes of this paragraph, the table for determining primary insurance amounts and maximum family benefits contained in this section in December 1978 shall be revised as provided by subsection (i) for each year after 1978.[349]

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[345] P.L. 101-508, §5117(a)(1)(B), struck out "The table for determining primary insurance amounts and maximum family benefits contained in this section in December 1978 shall be revised as provided by subsection (i) for each year after 1978.". For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4).

[346] P.L. 101-508, §5117(a)(1)(C), added subparagraph (B). For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4).

[347] P.L. 101-508, §5117(a)(1)(C), added subparagraph (C). For the effective date, see Vol. II, P. L. 101-508, §5117(a)(4).

[348] P.L. 101-508, §5117(a)(1)(C), added subparagraph (D). For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4).

[349] P.L. 101-508, §5117(a)(1)(C), added subparagraph (E). For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4).

(6)(A) In applying the table of benefits in effect in December 1978 under this section for purposes of the last sentence of paragraph (4), such table, revised as provided by subsection (i), as applicable, shall be extended for average monthly wages of less than $76.00 and primary insurance benefits (as determined under subsection (d)) of less than $16.20.

(B) The Secretary shall determine and promulgate in regulations the methodology for extending the table under subparagraph (A).

(7)(A) In the case of an individual whose primary insurance amount would be computed under paragraph (1) of this subsection, who—

(i) attains age 62 after 1985 (except where he or she became entitled to a disability insurance benefit before 1986 and remained so entitled in any of the 12 months immediately preceding his or her attainment of age 62), or

(ii) would attain age 62 after 1985 and becomes eligible for a disability insurance benefit after 1985,

and who first becomes eligible after 1985 for a monthly periodic payment (including a payment determined under subparagraph (C), but excluding a payment under the Railroad Retirement Act of 1974[350] or 1937[351]) which is based in whole or in part upon his or her earnings for service which did not constitute "employment" as defined in section 210 for purposes of this title (hereafter in this paragraph and in subsection (d)(3)[352] referred to as "noncovered service"), the primary insurance amount of that individual during his or her concurrent entitlement to such monthly periodic payment and to old-age or disability insurance benefits shall be computed or recomputed under subparagraph (B).

(B)(i) If paragraph (1) of this subsection would apply to such an individual (except for subparagraph (A) of this paragraph), there shall first be computed an amount equal to the individual's primary insurance amount under paragraph (1) of this subsection, except that for purposes of such computation the percentage of the individual's average indexed monthly earnings established by subparagraph (A)(i) of paragraph (1) shall be the percent specified in clause (ii). There shall then be computed (without regard to this paragraph) a second amount, which shall be equal to the individual's primary insurance amount under paragraph (1) of this subsection, except that such second amount shall be reduced by an amount equal to one-half of the portion of the monthly periodic payment which is attributable to noncovered service performed after 1956 (with such attribution being based on the proportionate number of years of such noncovered service) and to which the individual is entitled (or is deemed to be entitled) for the initial month of his or her concurrent entitlement to such monthly periodic payment and old-age or disability insurance benefits. The individual's primary insurance amount shall be the larger of the two amounts computed under this subparagraph (before the application of subsection (i)) and shall be deemed to be computed under paragraph (1) of this subsection for the purpose of applying other provisions of this title.

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[350] P.L. 75-162 [as amended by P.L. 93-445].

[351] P.L. 75-162.

[352] P.L. 101-508, §5117(a)(3)(E)(ii), struck out "(5)" and substituted "(3)". For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4).

(ii) For purposes of clause (i), the percent specified in this clause is—

(I) 80.0 percent with respect to individuals who become eligible (as defined in paragraph (3)(B)) for old-age insurance benefits (or became eligible as so defined for disability insurance benefits before attaining age 62) in 1986;

(II) 70.0 percent with respect to individuals who so become eligible in 1987;

(III) 60.0 percent with respect to individuals who so become eligible in 1988;

(IV) 50.0 percent with respect to individuals who so become eligible in 1989; and

(V) 40.0 percent with respect to individuals who so become eligible in 1990 or thereafter.

(C)(i) Any periodic payment which otherwise meets the requirements of subparagraph (A), but which is paid on other than a monthly basis, shall be allocated on a basis equivalent to a monthly payment (as determined by the Secretary), and such equivalent monthly payment shall constitute a monthly periodic payment for purposes of this paragraph.

(ii) In the case of an individual who has elected to receive a periodic payment that has been reduced so as to provide a survivor's benefit to any other individual, the payment shall be deemed to be increased (for purposes of any computation under this paragraph or subsection (d)(3)[353]) by the amount of such reduction.

(iii) For purposes of this paragraph, the term "periodic payment" includes a payment payable in a lump sum if it is a commutation of, or a substitute for, periodic payments.

(D) This paragraph shall not apply in the case of an individual who has 30 years or more of coverage[354]. In the case of an individual who has more than 20 years of coverage but less than 30 years of coverage (as so defined), the percent specified in the applicable subdivision of subparagraph (B)(ii) shall (if such percent is smaller than the applicable percent specified in the following table) be deemed to be the applicable percent specified in the following table:

If the number of such individual's years of coverage (as so defined) is:	**The applicable percent is:**
29	85 percent
28	80 percent
27	75 percent
26	70 percent
25	65 percent
24	60 percent
23	55 percent
22	50 percent
21	45 percent.

For purposes of this subparagraph, the term "year of coverage" shall have the meaning provided in paragraph (1)(C)(ii), except that the reference to "15 percent" therein shall be deemed to be a reference to "25 percent".[355]

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[353] P.L. 101-508, §5117(a)(3)(E)(ii), struck out "(5)" and substituted "(3)". For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4).

[354] P.L. 101-508, §5122(b)(1), struck out "(as defined in paragraph (1)(C)(ii))", effective November 5, 1990.

[355] P.L. 101-508, §5122(b)(2), added this sentence, effective November 5, 1990.

(E) This paragraph shall not apply in the case of an individual who on January 1, 1984—

(i) is an employee performing service to which social security coverage is extended on that date solely by reason of the amendments made by section 101 of the Social Security Amendments of 1983[356]; or

(ii) is an employee of a nonprofit organization which (on December 31, 1983) did not have in effect a waiver certificate under section 3121(k) of the Internal Revenue Code of 1954[357] and to the employees of which social security coverage is extended on that date solely by reason of the amendments made by section 102 of that Act, unless social security coverage had previously extended to service performed by such individual as an employee of that organization under a waiver certificate which was subsequently (prior to December 31, 1983) terminated.

Average Indexed Monthly Earnings; Average Monthly Wage

(b)(1) An individual's average indexed monthly earnings shall be equal to the quotient obtained by dividing—

(A) the total (after adjustment under paragraph (3)) of his wages paid in and self-employment income credited to his benefit computation years (determined under paragraph (2)), by

(B) the number of months in those years.

(2)(A) The number of an individual's benefit computation years equals the number of elapsed years reduced—

(i) in the case of an individual who is entitled to old-age insurance benefits (except as provided in the second sentence of this subparagraph), or who has died, by 5 years, and

(ii) in the case of an individual who is entitled to disability insurance benefits, by the number of years equal to one-fifth of such individual's elapsed years (disregarding any resulting fractional part of a year), but not by more than 5 years.

Clause (ii), once applicable with respect to any individual, shall continue to apply for purposes of determining such individual's primary insurance amount for purposes of any subsequent eligibility for disability or old-age insurance benefits unless prior to the month in which such eligibility begins there occurs a period of at least 12 consecutive months for which he was not entitled to a disability or an old-age insurance benefit. If an individual described in clause (ii) is living with a child (of such individual or his or her spouse) under the age of 3 in any calendar year which is included in such individual's computation base years, but which is not disregarded pursuant to clause (ii) or to subparagraph (B) (in determining such individual's benefit computation years) by reason of the reduction in the number of such individual's elapsed years under clause (ii), the number by which such elapsed years are reduced under this subparagraph pursuant to clause (ii) shall be increased by one (up to a combined total not exceeding 3) for each such calendar year; except that (I) no calendar year shall be disregarded by reason of this sentence (in determining such individual's benefit computation years) unless the individual was living with such child substantially throughout the period in which the child was alive and under the age of 3 in such year and the individual had no earnings as described in section 203(f)(5) in such year, (II) the particular calendar years to be disregarded under this sentence (in determining such benefit computation years) shall be those years (not otherwise disregarded under clause (ii)) which, before the application of section 215(f), meet the conditions of subclause (I), and (III) this sentence shall apply only to the extent that its application would not result in a lower primary insurance amount. The number of an individual's benefit computation years as determined under this subparagraph shall in no case be less than 2.

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[356] P.L. 98-21.

[357] P.L. 83-591; however, §3121(k) was repealed by P.L. 98-21, §102(b)(2).

(B) For purposes of this subsection with respect to any individual—

(i) the term "benefit computation years" means those computation base years, equal in number to the number determined under subparagraph (A), for which the total of such individual's wages and self-employment income, after adjustment under paragraph (3), is the largest;

(ii) the term "computation base years" means the calendar years after 1950 and before—

(I) in the case of an individual entitled to old-age insurance benefits, the year in which occurred (whether by reason of section 202(j)(1) or otherwise) the first month of that entitlement; or

(II) in the case of an individual who has died (without having become entitled to old-age insurance benefits), the year succeeding the year of his death;

except that such term excludes any calendar year entirely included in a period of disability; and

(iii) the term "number of elapsed years" means (except as otherwise provided by section 104(j)(2) of the Social Security Amendments of 1972[358]) the number of calendar years after 1950 (or, if later, the year in which the individual attained age 21) and before the year in which the individual died, or, if it occurred earlier (but after 1960), the year in which he attained age 62; except that such term excludes any calendar year any part of which is included in a period of disability.

(3)(A) Except as provided by subparagraph (B), the wages paid in and self-employment income credited to each of an individual's computation base years for purposes of the selection therefrom of benefit computation years under paragraph (2) shall be deemed to be equal to the product of—

(i) the wages and self-employment income paid in or credited to such year (as determined without regard to this subparagraph), and

(ii) the quotient obtained by dividing—

(I) the deemed average total wages (as defined in section 209(k)(1))[359] for the second calendar year[360] preceding the earliest of the year of the individual's death, eligibility for an old-age insurance benefit, or eligibility for a disability insurance benefit (except that the year in which the individual dies, or becomes eligible, shall not be considered as such year if the individual was entitled to disability insurance benefits for any month in the 12-month period immediately preceding such death or eligibility, but there shall be counted instead the year of the individual's eligibility for the disability insurance benefit to which he was entitled in such 12-month period), by

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[358] P.L. 92-603.

[359] P.L. 101-239, §10208(b)(1)(A), struck out "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1)[*]) reported to the Secretary of the Treasury or his delegate" and substituted "the deemed average total wages (as defined in section 209(k)(1))", applicable with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

[*] P.L. 101-239, §10208(d)(2)(A)(i), struck out "209(a)" and substituted "209(a)(1)", effective December 19, 1989.

[360] P.L. 101-239, §10208(b)(1)(C), struck out "(after 1976)", applicable with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

(II) the deemed average total wages (as so defined)[361] for the computation base year for which the determination is made.

(B) Wages paid in or self-employment income credited to an individual's computation base year which—

(i) occurs after the second calendar year specified in subparagraph (A)(ii)(I), or

(ii) is a year treated under subsection (f)(2)(C) as though it were the last year of the period specified in paragraph (2)(B)(ii),

shall be available for use in determining an individual's benefit computation years, but without applying subparagraph (A) of this paragraph.

(4) For purposes of determining the average monthly wage of an individual whose primary insurance amount is computed (after 1978) under section 215(a) or 215(d) as in effect (except with respect to the table contained therein) in December 1978, by reason of subsection (a)(4)(B), this subsection as in effect in December 1978 shall remain in effect, except that paragraph (2)(C) (as then in effect) shall be deemed to provide that "computation base years" include only calendar years in the period after 1950 (or 1936, if applicable) and prior to the year in which occurred the first month for which the individual was eligible (as defined in subsection (a)(3)(B) as in effect in January 1979) for an old-age or disability insurance benefit, or, if earlier, the year in which he died. Any calendar year all of which is included in a period of disability shall not be included as a computation base year for such purposes.

Application of Prior Provisions in Certain Cases

(c) Subject to the amendments made by section 5117 of the Omnibus Budget Reconciliation Act of 1990, this[362] subsection as in effect in December 1978 shall remain in effect with respect to an individual to whom subsection (a)(1) does not apply by reason of the individual's eligibility for an old-age or disability insurance benefit, or the individual's death, prior to 1979.

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[361] P.L. 101-239, §10208(b)(1)(B), struck out "the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate" and substituted "the deemed average total wages (as so defined)", applicable with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

[362] P.L. 101-508, §5117(a)(3)(C), struck out "This" and substituted "Subject to the amendments made by section 5117 of the Omnibus Budget Reconciliation Act of 1990, this". For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4).

Primary Insurance Benefit Under 1939 Act

(d)(1) For purposes of column I of the table appearing in subsection (a), as that subsection was in effect in December 1977, an individual's primary insurance benefit shall be computed as follows:

(A) The individual's average monthly wage shall be determined as provided in subsection (b), as in effect in December 1977 (but without regard to paragraph (4) thereof and subject to section 104(j)(2) of the Social Security Amendments of 1972[363]), except that for purposes of paragraphs (2)(C) and (3) of that subsection (as so in effect) 1936 shall be used instead of 1950.

(B) For purposes of subparagraphs (B) and (C) of subsection (b)(2) (as so in effect)—

(i) the total wages prior to 1951 (as defined in subparagraph (C) of this paragraph) of an individual—

(I) shall, in the case of an individual who attained age 21 prior to 1950, be divided by the number of years (hereinafter in this subparagraph referred to as the "divisor") elapsing after the year in which the individual attained age 20, or 1936 if later, and prior to the earlier of the year of death or 1951, except that such divisor shall not include any calendar year entirely included in a period of disability, and in no case shall the divisor be less than one, and

(II) shall, in the case of an individual who died before 1950 and before attaining age 21, be divided by the number of years (hereinafer in this subparagraph referred to as the "divisor") elapsing after the second year prior to the year of death, or 1936 if later, and prior to the year of death, and in no case shall the divisor be less than one; and

(ii) the total wages prior to 1951 (as defined in subparagraph (C) of this paragraph) of an individual who either attained age 21 after 1949 or died after 1949 before attaining age 21, shall be divided by the number of years (hereinafter in this subparagraph referred to as the "divisor") elapsing after 1949 and prior to 1951.[364]

The quotient so obtained shall be deemed to be the individual's wages credited to each of the years which were used in computing the amount of the divisor, except that—

(iii) if the quotient exceeds $3,000, only $3,000 shall be deemed to be the individual's wages for each of the years which were used in computing the amount of the divisor, and the remainder of the individual's total wages prior to 1951 (I) if less than $3,000, shall be deemed credited to the computation base year (as defined in subsection (b)(2) as in effect in December 1977) immediately preceding the earliest year used in computing the amount of the divisor, of (II) if $3,000 or more, shall be deemed credited, in $3,000 increments, to the computation base year (as so defined) immediately preceding the earliest year used in computing the amount of the divisor and to each of the computation base years (as so defined) consecutively preceding that year, with any remainder less than $3,000 being credited to the computation base year (as so defined) immediately preceding the earliest year to which a full $3,000 increment was credited; and[365]

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[363] P.L. 101-508, §5117(a)(2)(A)(i), inserted "and subject to section 104(j)(2) of the Social Security Amendments of 1972". For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4).

[364] P.L. 101-508, §5117(a)(2)(A)(ii), amended clauses (i) and (ii).
For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4). [For clauses (i) and (ii) as they formerly read, see Vol. III, P.L. 101-508.]

(iv) no more than $42,000 may be taken into account, for purposes of this subparagraph, as total wages after 1936 and prior to 1951.

(C) For the purposes of subparagraph (B), "total wages prior to 1951" with respect to an individual means the sum of (i) remuneration credited to such individual prior to 1951 on the records of the Secretary, (ii) wages deemed paid prior to 1951 to such individual under section 217, (iii) compensation under the Railroad Retirement Act of 1937[366] prior to 1951 creditable to him pursuant to this title, and (iv) wages deemed paid prior to 1951 to such individual under section 231.

(D) The individual's primary insurance benefit shall be 40 percent of the first $50 of his average monthly wage as computed under this subsection, plus 10 percent of the next $200 of his average monthly wage, increased by 1 percent for each increment year. The number of increment years is the number, not more than 14 nor less than 4, that is equal to the individual's total wages prior to 1951 divided by $1,650 (disregarding any fraction).

(2) The provisions of this subsection shall be applicable only in the case of an individual—

(A) with respect to whom at least one of the quarters elapsing prior to 1951 is a quarter of coverage;

(B) [367] who attained age 22 after 1950 and with respect to whom less than six of the quarters elapsing after 1950 are quarters of coverage, or who attained such age before 1951; and

(C)(i) who becomes entitled to benefits under section 202(a) or 223 or who dies, or

(ii) whose primary insurance amount is required to be recomputed under paragraph (2), (6), or (7) of subsection (f) or under section 231.[368]

(3)[369] In the case of an individual whose primary insurance amount is not computed under paragraph (1) of subsection (a) by reason of paragraph (4)(B)(ii) of that subsection, who—

(A) attains age 62 after 1985 (except where he or she became entitled to a disability insurance benefit before 1986, and remained so entitled in any of the 12 months immediately preceding his or her attainment of age 62), or

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[365] P.L. 101-508, §5117(a)(2)(B), amended clause (iii) in its entirety. For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4). [For clause (iii) as it formerly read, see Vol. III, P.L. 101-508.]

[366] P.L. 75-162.

[367] P.L. 101-508, §5117(a)(2)(C)(i), struck out "except as provided in paragraph (3),". For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4).

[368] P.L. 101-508, §5117(a)(2)(C)(ii), amended subparagraph (C) in its entirety. For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4). [For subparagraph (C) as it formerly read, see Vol. III; P.L. 101-508.]

[369] P.L. 101-508, §5117(a)(2)(C)(iii), struck out paragraphs (3) and (4). For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4). [For paragraphs (3) and (4) as they formerly read, see Vol. III; P.L. 101-508.]

P.L. 101-508, §5117(a)(3)(E)(i), redesignated paragraph (5) as paragraph (3). For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4).

(B) would attain age 62 after 1985 and becomes eligible for a disability insurance benefit after 1985,

and who first becomes eligible after 1985 for a monthly periodic payment (including a payment determined under subsection (a)(7)(C), but excluding a payment under the Railroad Retirement Act of 1974[370] or 1937[371]) which is based (in whole or in part) upon his or her earnings in noncovered service, the primary insurance amount of such individual during his or her concurrent entitlement to such monthly periodic payment and to old-age or disability insurance benefits shall be the primary insurance amount computed or recomputed under this subsection (without regard to this paragraph and before the application of subsection (i)) reduced by an amount equal to the smaller of—

(i) one-half of the primary insurance amount (computed without regard to this paragraph and before the application of subsection (i)), or

(ii) one-half of the portion of the monthly periodic payment (or payment determined under subsection (a)(7)(C)) which is attributable to noncovered service performed after 1956 (with such attribution being based on the proportionate number of years of such noncovered service) and to which that individual is entitled (or is deemed to be entitled) for the initial month of such concurrent entitlement.

This paragraph shall not apply in the case of any individual to whom subsection (a)(7) would not apply by reason of subparagraph (E) or the first sentence of subparagraph (D) thereof.

Certain Wages and Self-Employment Income Not To Be Counted

(e) For the purposes of subsections (b) and (d)—

(1) in computing an individual's average indexed monthly earnings or, in the case of an individual whose primary insurance amount is computed under section 215(a) as in effect prior to January 1979, average monthly wage, there shall not be counted the excess over $3,600 in the case of any calendar year after 1950 and before 1955, the excess over $4,200 in the case of any calendar year after 1954 and before 1959, the excess over $4,800 in the case of any calendar year after 1958 and before 1966, the excess over $6,600 in the case of any calendar year after 1965 and before 1968, the excess over $7,800 in the case of any calendar year after 1967 and before 1972, the excess over $9,000 in the case of any calendar year after 1971 and before 1973, the excess over $10,800 in the case of any calendar year after 1972 and before 1974, the excess over $13,200 in the case of any calendar year after 1973 and before 1975, and the excess over an amount equal to the contribution and benefit base (as determined under section 230) in the case of any calendar year after 1974 with respect to which such contribution and benefit base is effective, (before the application, in the case of average indexed monthly earnings, of subsection (b)(3)(A)) of (A) the wages paid to him in such year, plus (B) the self-employment income credited to such year (as determined under section 212); and

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[370] P.L. 75-162 [as amended by P.L. 93-445].

[371] P.L. 75-162.

(2) if an individual's average indexed monthly earnings or, in the case of an individual whose primary insurance amount is computed under section 215(a) as in effect prior to January 1979, average monthly wage, computed under subsection (b) or for the purposes of subsection (d) is not a multiple of $1, it shall be reduced to the next lower multiple of $1.

Recomputation of Benefits

(f)(1) After an individual's primary insurance amount has been determined under this section, there shall be no recomputation of such individual's primary insurance amount except as provided in this subsection or, in the case of a World War II veteran who died prior to July 27, 1954, as provided in section 217(b).

(2)(A) If an individual has wages or self-employment income for a year after 1978 for any part of which he is entitled to old-age or disability insurance benefits, the Secretary shall, at such time or times and within such period as he may by regulation prescribe, recompute the individual's primary insurance amount for that year.

(B) For the purpose of applying subparagraph (A) of subsection (a)(1) to the average indexed monthly earnings of an individual to whom that subsection applies and who receives a recomputation under this paragraph, there shall be used, in lieu of the amounts established by subsection (a)(1)(B) for purposes of clauses (i) and (ii) of subsection (a)(1)(A), the amounts so established that were (or, in the case of an individual described in subsection (a)(4)(B), would have been) used in the computation of such individual's primary insurance amount prior to the application of this subsection.

(C) A recomputation of any individual's primary insurance amount under this paragraph shall be made as provided in subsection (a)(1) as though the year with respect to which it is made is the last year of the period specified in subsection (b)(2)(B)(ii); and subsection (b)(3)(A) shall apply with respect to any such recomputation as it applied in the computation of such individual's primary insurance amount prior to the application of this subsection.

(D) A recomputation under this paragraph with respect to any year shall be effective—

(i) in the case of an individual who did not die in that year, for monthly benefits beginning with benefits for January of the following year; or

(ii) in the case of an individual who died in that year, for monthly benefits beginning with benefits for the month in which he died.

[(3) Repealed.[372]]

(4) A recomputation shall be effective under this subsection only if it increases the primary insurance amount by at least $1.

(5) In the case of a man who became entitled to old-age insurance benefits and died before the month in which he attained retirement age (as defined in section 216(l)), the Secretary shall recompute his primary insurance amount as provided in subsection (a) as though he became entitled to old-age insurance ~~benefits~~ in the month in which he died; except that (i) his computation base years referred to in subsection (b)(2) shall include the year in which he died, and (ii) his

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[372] P.L. 95-216, §201(f)(2); 91 Stat. 1521.

elapsed years referred to in subsection (b)(3) shall not include the year in which he died or any year thereafter. Such recomputation of such primary insurance amount shall be effective for and after the month in which he died.

(6) Upon the death after 1967 of an individual entitled to benefits under section 202(a) or section 223, if any person is entitled to monthly benefits or a lump-sum death payment, on the wages and self-employment income of such individual, the Secretary shall recompute the decedent's primary insurance amount, but only if the decedent during his lifetime was paid compensation which was treated under section 205(o) as remuneration for employment.

(7) This subsection as in effect in December 1978 shall continue to apply to the recomputation of a primary insurance amount computed under subsection (a) or (d) as in effect (without regard to the table in subsection (a)) in that month, and, where appropriate, under subsection (d) as in effect in December 1977, including a primary insurance amount computed under any such subsection whose operation is modified as a result of the amendments made by section 5117 of the Omnibus Budget Reconciliation Act of 1990[373] For purposes of recomputing a primary insurance amount determined under subsection (a) or (d) (as so in effect) in the case of an individual to whom those subsections apply by reason of subsection (a)(4)(B) as in effect after December 1978, no remuneration shall be taken into account for the year in which the individual initially became eligible for an old-age or disability insurance benefit or died, or for any year thereafter, and (effective January 1982) the recomputation shall be modified by the application of subsection (a)(6) where applicable.

(8) The Secretary shall recompute the primary insurance amounts applicable to beneficiaries whose benefits are based on a primary insurance amount which was computed under subsection (a)(3) effective prior to January 1979, or would have been so computed if the dollar amount specified therein were $11.50. Such recomputation shall be effective January 1979, and shall include the effect of the increase in the dollar amount provided by subsection (a)(1)(C)(i). Such primary insurance amount shall be deemed to be provided under such section for purposes of subsection (i).

(9)(A) In the case of an individual who becomes entitled to a periodic payment determined under subsection (a)(7)(A) (including a payment determined under subsection (a)(7)(C)) in a month subsequent to the first month in which he or she becomes entitled to an old-age or disability insurance benefit, and whose primary insurance amount has been computed without regard to either such subsection or subsection (d)(3)[374], such individual's primary insurance amount shall be recomputed (notwithstanding paragraph (4) of this subsection), in accordance with either such subsection or subsection (d)(3)[375], as may be applicable, effective with the first month of his or her concurrent entitlement to such benefit and such periodic payment.

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[373] P.L. 101-508, §5117(a)(3)(D), struck out the period and substituted ", including a primary insurance amount computed under any such subsection whose operation is modified as a result of the amendments made by section 5117 of the Omnibus Budget Reconciliation Act of 1990". As in original. No final punctuation. For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4).

[374] P.L. 101-508, §5117(a)(3)(E)(ii), struck out "(5)" and substituted "(3)". For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4).

[375] P.L. 101-508, §5117(a)(3)(E)(ii), struck out "(5)" and substituted "(3)". For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4).

(B) If an individual's primary insurance amount has been computed under subsection (a)(7) or (d)(3)[376], and it becomes necessary to recompute that primary insurance amount under this subsection—

(i) so as to increase the monthly benefit amount payable with respect to such primary insurance amount (except in the case of the individual's death), such increase shall be determined as though the recomputed primary insurance amount were being computed under subsection (a)(7) or (d)(3)[377], or

(ii) by reason of the individual's death, such primary insurance amount shall be recomputed without regard to (and as though it had never been computed with regard to) subsection (a)(7) or (d)(3)[378].

Rounding of Benefits

(g) The amount of any monthly benefit computed under section 202 or 223 which (after any reduction under sections 203(a) and 224 and any deduction under section 203(b), and after any deduction under section 1840(a)(1)) is not a multiple of $1 shall be rounded to the next lower multiple of $1.

Service of Certain Public Health Service Officers

(h)(1) Notwithstanding the provisions of subchapter III of chapter 83 of title 5, United States Code, remuneration paid for service to which the provisions of section 210(l)(1) of this Act are applicable and which is performed by an individual as a commissioned officer of the Reserve Corps of the Public Health Service prior to July 1, 1960, shall not be included in computing entitlement to or the amount of any monthly benefit under this title, on the basis of his wages and self-employment income, for any month after June 1960 and prior to the first month with respect to which the Director of the Office of Personnel Management certifies to the Secretary that, by reason of a waiver filed as provided in paragraph (2), no further annuity will be paid to him, his wife, and his children, or, if he has died, to his widow and children, under subchapter III of chapter 83 of title 5, United States Code, on the basis of such service.

(2) In the case of a monthly benefit for a month prior to that in which the individual, on whose wages and self-employment income such benefit is based, dies, the waiver must be filed by such individual; and such waiver shall be irrevocable and shall constitute a waiver on behalf of himself, his wife, and his children. If such individual did not file such a waiver before he died, then in the case of a benefit for the month in which he died or any month thereafter, such waiver must be filed by his widow, if any, and by or on behalf of all his children, if any; and such waivers shall be irrevocable. Such a waiver by a child shall be filed by his legal guardian or guardians, or, in the absence thereof, by the person (or persons) who has the child in his care.

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[376] P.L. 101-508, §5117(a)(3)(E)(iii), struck out "(5)" and substituted "(3)". For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4).

[377] P.L. 101-508, §5117(a)(3)(E)(iii), struck out "(5)" and substituted "(3)". For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4).

[378] P.L. 101-508, §5117(a)(3)(E)(iii), struck out "(5)" and substituted "(3)". For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4).

Cost-of-Living Increases in Benefits[379]

(i)(1) For purposes of this subsection—

(A) the term "base quarter" means (i) the calendar quarter ending on September 30 in each year after 1982, or (ii) any other calendar quarter in which occurs the effective month of a general benefit increase under this title;

(B) the term "cost-of-living computation quarter" means a base quarter, as defined in subparagraph (A)(i), with respect to which the applicable increase percentage is greater than zero; except that there shall be no cost-of-living computation quarter in any calendar year if in the year prior to such year a law has been enacted providing a general benefit increase under this title or if in such prior year such a general benefit increase becomes effective;

(C) the term "applicable increase percentage" means—

(i) with respect to a base quarter or cost-of-living computation quarter in any calendar year before 1984, or in any calendar year after 1983 and before 1989 for which the OASDI fund ratio is 15.0 percent or more, or in any calendar year after 1988 for which the OASDI fund ratio is 20.0 percent or more, the CPI increase percentage; and

(ii) with respect to a base quarter or cost-of-living computation quarter in any calendar year after 1983 and before 1989 for which the OASDI fund ratio is less than 15.0 percent, or in any calendar year after 1988 for which the OASDI fund ratio is less than 20.0 percent, the CPI increase percentage or the wage increase percentage, whichever (with respect to that quarter) is the lower;

(D) the term "CPI increase percentage", with respect to a base quarter or cost-of-living computation quarter in any calendar year, means the percentage (rounded to the nearest one-tenth of 1 percent) by which the Consumer Price Index for that quarter (as prepared by the Department of Labor) exceeds such index for the most recent prior calendar quarter which was a base quarter under subparagraph (A)(ii) or, if later, the most recent cost-of-living computation quarter under subparagraph (B);

(E) the term "wage increase percentage", with respect to a base quarter or cost-of-living computation quarter in any calendar year, means the percentage (rounded to the nearest one-tenth of 1 percent) by which the SSA average wage index for the year immediately preceding such calendar year exceeds such index for the year immediately preceding the most recent prior calendar year which included a base quarter under subparagraph (A)(ii) or, if later, which included a cost-of-living computation quarter;

(F) the term "OASDI fund ratio", with respect to any calendar year, means the ratio of—

(i) the combined balance in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund as of the beginning of such year, including the taxes transferred under section 201(a) on the first day of such year and reduced by the outstanding amount of any loan (including interest thereon) theretofore made to either such Fund from the Federal Hospital Insurance Trust Fund under section 201(l), to

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[379] See Vol. II, P.L. 99-177, Title II, §255, with respect to exemption of certain benefits from reduction.

(ii) the total amount which (as estimated by the Secretary) will be paid from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund during such calendar year for all purposes authorized by section 201 (other than payments of interest on, or repayments of, loans from the Federal Hospital Insurance Trust Fund under section 201(l)), but excluding any transfer payments between such trust funds and reducing the amount of any transfers to the Railroad Retirement Account by the amount of any transfers into either such trust fund from that Account;

(G) the term "SSA average wage index", with respect to any calendar year, means the amount determined for such calendar year under subsection (b)(3)(A)(ii)(I)[380]; and

(H) the Consumer Price Index for a base quarter, a cost-of-living computation quarter, or any other calendar quarter shall be the arithmetical mean of such index for the 3 months in such quarter.

(2)(A)(i) The Secretary shall determine each year beginning with 1975 (subject to the limitation in paragraph (1)(B)) whether the base quarter (as defined in paragraph (1)(A)(i)) in such year is a cost-of-living computation quarter.

(ii) If the Secretary determines that the base quarter in any year is a cost-of-living computation quarter, he shall, effective with the month of December of that year as provided in subparagraph (B), increase—

(I) the benefit amount to which individuals are entitled for that month under section 227 or 228,

(II) the primary insurance amount of each other individual on which benefit entitlement is based under this title, and

(III) the amount of total monthly benefits based on any primary insurance amount which is permitted under section 203 (and such total shall be increased, unless otherwise so increased under another provision of this title, at the same time as such primary insurance amount) or, in the case of a primary insurance amount computed under subsection (a) as in effect (without regard to the table contained therein) prior to January 1979, the amount to which the beneficiaries may be entitled under section 203 as in effect in December 1978, except as provided by section 203(a)(7) and (8) as in effect after December 1978.

The increase shall be derived by multiplying each of the amounts described in subdivisions (I), (II), and (III) (including each of those amounts as previously increased under this subparagraph) by the applicable increase percentage; and any amount so increased that is not a multiple of $0.10 shall be decreased to the next lower multiple of $0.10. Any increase under this subsection in a primary insurance amount determined under subparagraph (C)(i) of subsection (a)(1) shall be applied after the initial determination of such primary insurance amount under that subparagraph (with the amount of such increase, in the case of an individual who becomes eligible for old-age or disability insurance benefits or dies in a calendar year after 1979, being determined from the range of possible primary insurance amounts published by the Secretary under the last sentence of subparagraph (D)).

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[380] P.L. 101-239, §10208(b)(3), struck out "the average of the total wages reported to the Secretary of the Treasury or his delegate as determined for purposes of subsection (b)(3)(A)(ii)" and substituted "the amount determined for such calendar year under subsection (b)(3)(A)(ii)(I)", applicable with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

(iii) In the case of an individual who becomes eligible for an old-age or disability insurance benefit, or who dies prior to becoming so eligible, in a year in which there occurs an increase provided under clause (ii), the individual's primary insurance amount (without regard to the time of entitlement to that benefit) shall be increased (unless otherwise so increased under another provision of this title and, with respect to a primary insurance amount determined under subsection (a)(1)(C)(i)(I) in the case of an individual to whom that subsection (as in effect in December 1981) applied, subject to the provisions of subsection (a)(1)(C)(i) and clauses (iv) and (v) of this subparagraph (as then in effect)) by the amount of that increase and subsequent applicable increases, but only with respect to benefits payable for months after November of that year.

(B) The increase provided by subparagraph (A) with respect to a particular cost-of-living computation quarter shall apply in the case of monthly benefits under this title for months after November of the calendar year in which occurred such cost-of-living computation quarter, and in the case of lump-sum death payments with respect to deaths occurring after November of such calendar year.

(C)(i) Whenever the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall notify the House Committee on Ways and Means and the Senate Committee on Finance of such determination within 30 days after the close of such quarter, indicating the amount of the benefit increase to be provided, his estimate of the extent to which the cost of such increase would be met by an increase in the contribution and benefit base under section 230 and the estimated amount of the increase in such base, the actuarial estimates of the effect of such increase, and the actuarial assumptions and methodology used in preparing such estimates.

(ii) The Secretary shall determine and promulgate the OASDI fund ratio for the current calendar year and the SSA wage index for the preceding calendar year before November 1 of the current calendar year, based upon the most recent data then available, and shall include a statement of such fund ratio and wage index (and of the effect such ratio and the level of such index may have upon benefit increases under this subsection) in any notification made under clause (i) and any determination published under subparagraph (D).

(D) If the Secretary determines that a base quarter in a calendar year is also a cost-of-living computation quarter, he shall publish in the Federal Register within 45 days after the close of such quarter a determination that a benefit increase is resultantly required and the percentage thereof. He shall also publish in the Federal Register at that time (i) a revision of the range of the primary insurance amounts which are possible after the application of this subsection based on the dollar amount specified in subparagraph (C)(i) of subsection (a)(1) (with such revised primary insurance amounts constituting the increased amounts determined for purposes of such subparagraph (C)(i) under this subsection), or specified in subsection (a)(3) as in effect prior to 1979, and (ii) a revision of the range of maximum family benefits which correspond to such primary insurance amounts (with such maximum benefits being effective notwithstanding section 203(a) except for paragraph (3)(B) thereof (or paragraph (2) thereof as in effect prior to 1979)). Notwithstanding the preceding sentence, such revision of maximum family benefits shall be subject to paragraph (6) of section 203(a) (as added by section 101(a)(3) of the Social Security Disability Amendments of 1980[381]).

(3) As used in this subsection, the term "general benefit increase under this title" means an increase (other than an increase under this subsection) in all primary insurance amounts on which monthly insurance benefits under this title are based.

(4) This subsection as in effect in December 1978, and as amended by sections 111(a)(6), 111(b)(2), and 112 of the Social Security Amendments of 1983[382] and by section 9001 of the Omnibus Budget Reconciliation Act of 1986[383], shall continue to apply to subsections (a) and (d), as then in effect and as amended by section 5117 of the Omnibus Budget Reconciliation Act of 1990[384], for purposes of computing the primary insurance amount of an individual to whom subsection (a), as in effect after December 1978, does not apply (including an individual to whom subsection (a) does not apply in any year by reason of paragraph (4)(B) of that subsection (but the application of this subsection in such cases shall be modified by the application of subdivision (I) in the last sentence of paragraph (4) of that subsection)), except that for this purpose, in applying paragraphs (2)(A)(ii), (2)(D)(iv), and (2)(D)(v) of this subsection as in effect in December 1978, the phrase "increased to the next higher multiple of $0.10" shall be deemed to read "decreased to the next lower multiple of $0.10". For purposes of computing primary insurance amounts and maximum family benefits (other than primary insurance amounts and maximum family benefits for individuals to whom such paragraph (4)(B) applies), the Secretary shall revise the table of benefits contained in subsection (a), as in effect in December 1978, in accordance with the requirements of paragraph (2)(D) of this subsection as then in effect, except that the requirement in such paragraph (2)(D) that the Secretary publish such revision of the table of benefits in the Federal Register shall not apply.

(5)(A) If—

(i) with respect to any calendar year the "applicable increase percentage" was determined under clause (ii) of paragraph (1)(C) rather than under clause (i) of such paragraph, and the increase becoming effective under paragraph (2) in such year was accordingly determined on the basis of the wage increase percentage rather than the CPI increase percentage (or there was no such increase becoming effective under paragraph (2) in that year because there was no wage increase percentage greater than zero), and

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[381] P.L. 96-265.

[382] P.L. 98-21.

[383] P.L. 99-509.

[384] P.L. 101-508, §5117(a)(3)(A), inserted "and as amended by section 5117 of the Omnibus Budget Reconciliation Act of 1990". For the effective date, see Vol. II, P.L. 101-508, §5117(a)(4).

(ii) for any subsequent calendar year in which an increase under paragraph (2) becomes effective the OASDI fund ratio is greater than 32.0 percent,

then each of the amounts described in subdivisions (I), (II), and (III) of paragraph (2)(A)(ii), as increased under paragraph (2) effective with the month of December in such subsequent calendar year, shall be further increased (effective with such month) by an additional percentage, which shall be determined under subparagraph (B) and shall apply as provided in subparagraph (C). Any amount so increased that is not a multiple of $0.10 shall be decreased to the next lower multiple of $0.10.

(B) The applicable additional percentage by which the amounts described in subdivisions (I), (II), and (III) of paragraph (2)(A)(ii) are to be further increased under subparagraph (A) in the subsequent calendar year involved shall be the amount derived by—

(i) subtracting (I) the compounded percentage benefit increases that were actually paid under paragraph (2) and this paragraph from (II) the compounded percentage benefit increases that would have been paid if all increases under paragraph (2) had been made on the basis of the CPI increase percentage,

(ii) dividing the difference by the sum of the compounded percentage in clause (i)(I) and 100 percent, and

(iii) multiplying such quotient by 100 so as to yield such applicable additional percentage (which shall be rounded to the nearest one-tenth of 1 percent),

with the compounded increases referred to in clause (i) being measured—

(iv) in the case of amounts described in subdivision (I) of paragraph (2)(A)(ii), over the period beginning with the calendar year in which monthly benefits described in such subdivision were first increased on the basis of the wage increase percentage and ending with the year before such subsequent calendar year, and

(v) in the case of amounts described in subdivisions (II) and (III) of paragraph (2)(A)(ii), over the period beginning with the calendar year in which the individual whose primary insurance amount is increased under such subdivision (II) became eligible (as defined in subsection (a)(3)(B)) for the old-age or disability insurance benefit that is being increased under this subsection, or died before becoming so eligible, and ending with the year before such subsequent calendar year;

except that if the Secretary determines in any case that the application (in accordance with subparagraph (C)) of the additional percentage as computed under the preceding provisions of this subparagraph would cause the OASDI fund ratio to fall below 32.0 percent in the calendar year immediately following such subsequent year, he shall reduce such applicable additional percentage to the extent necessary to ensure that the OASDI fund ratio will remain at or above 32.0 percent through the end of such following year.

(C) Any applicable additional percentage increase in an amount described in subdivision (I), (II), or (III) of paragraph (2)(A)(ii), made under this paragraph in any calendar year, shall thereafter be treated for all the purposes of this Act as a part of the increase made in such amount under paragraph (2) for that year.

OTHER DEFINITIONS

Sec. 216. [42 U.S.C. 416] For the purposes of this title—

Spouse; Surviving Spouse

(a)(1) The term "spouse" means a wife as defined in subsection (b) or a husband as defined in subsection (f).

(2) The term "surviving spouse" means a widow as defined in subsection (c) or a widower as defined in subsection (g).

Wife

(b) The term "wife" means the wife of an individual, but only if she (1) is the mother of his son or daughter, (2) was married to him for a period of not less than one year immediately preceding the day on which her application is filed, or (3) in the month prior to the month of her marriage to him (A) was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (b), (e), or (h) of section 202, (B) had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (subject, however, to section 202(s)), or (C) was entitled to, or upon application therefor and attainment of the required age (if any) would have been entitled to, a widow's, child's (after attainment of age 18), or parent's insurance annuity under section 2 of the Railroad Retirement Act of 1974[385], as amended. For purposes of clause (2), a wife shall be deemed to have been married to an individual for a period of one year throughout the month in which occurs the first anniversary of her marriage to such individual. For purposes of subparagraph (C) of section 202(b)(1), a divorced wife shall be deemed not to be married throughout the month in which she becomes divorced.

Widow

(c) The term "widow" (except when used in the first sentence of section 202(i)) means the surviving wife of an individual, but only if (1) she is the mother of his son or daughter, (2) she legally adopted his son or daughter while she was married to him and while such son or daughter was under the age of eighteen, (3) he legally adopted her son or daughter while she was married to him and while such son or daughter was under the age of eighteen, (4) she was married to him at the time both of them legally adopted a child under the age of eighteen, (5) she was married to him for a period of not less than nine months immediately prior to the day on which he died, or (6) in the month prior to the month of her marriage to him (A) she was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (b), (e), or (h) of section 202, (B) she had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (subject, however, to section 202(s)), or (C) she was entitled to, or upon application therefor and attainment of the required age (if any) would have been entitled to, a widow's, child's (after attainment of age 18), or parent's insurance annuity under section 2 of the Railroad Retirement Act of 1974, as amended.

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[385] P.L. 75-162 [as amended by P.L. 93-445].

Divorced Spouses; Divorce

(d)(1) The term "divorced wife" means a woman divorced from an individual, but only if she had been married to such individual for a period of 10 years immediately before the date the divorce became effective.

(2) The term "surviving divorced wife" means a woman divorced from an individual who has died, but only if she had been married to the individual for a period of 10 years immediately before the date the divorce became effective.

(3) The term "surviving divorced mother" means a woman divorced from an individual who has died, but only if (A) she is the mother of his son or daughter, (B) she legally adopted his son or daughter while she was married to him and while such son or daughter was under the age of 18, (C) he legally adopted her son or daughter while she was married to him and while such son or daughter was under the age of 18, or (D) she was married to him at the time both of them legally adopted a child under the age of 18.

(4) The term "divorced husband" means a man divorced from an individual, but only if he had been married to such individual for a period of 10 years immediately before the date the divorce became effective.

(5) The term "surviving divorced husband" means a man divorced from an individual who has died, but only if he had been married to the individual for a period of 10 years immediately before the divorce became effective.

(6) The term "surviving divorced father" means a man divorced from an individual who has died, but only if (A) he is the father of her son or daughter, (B) he legally adopted her son or daughter while he was married to her and while such son or daughter was under the age of 18, (C) she legally adopted his son or daughter while he was married to her and while such son or daughter was under the age of 18, or (D) he was married to her at the time both of them legally adopted a child under the age of 18.

(7) The term "surviving divorced parent" means a surviving divorced mother as defined in paragraph (3) of this subsection or a surviving divorced father as defined in paragraph (6).

(8) The terms "divorce" and "divorced" refer to a divorce a vinculo matrimonii.

Child

(e) The term "child" means (1) the child or legally adopted child of an individual, (2) a stepchild who has been such stepchild for not less than one year immediately preceding the day on which application for child's insurance benefits is filed or (if the insured individual is deceased) not less than nine months immediately preceding the day on which such individual died, and (3) a person who is the grandchild or stepgrandchild of an individual or his spouse, but only if (A) there was no natural or adoptive parent (other than such a parent who was under a disability, as defined in section 223(d)) of such person living at the time (i) such individual became entitled to old-age insurance benefits or disability insurance benefits or died, or (ii) if such individual had a period of disability which continued until such individual became entitled to old-age insurance benefits or disability insurance benefits, or died, at the time such period of disability began, or (B) such person was legally adopted after the death of such individual by such individual's surviving spouse in an adoption that was decreed by a court of competent jurisdiction within the United States and such person's natural or adopting parent or stepparent was not living in such individual's household and making regular contributions toward such person's support at the time such individual died. For purposes of clause (1), a person shall be deemed, as of the date of death of an individual, to be the legally adopted child of such individual if such person was either living with or receiving at least one-half of his support from such individual at the time of such individual's death[386] and was legally adopted by such individual's surviving spouse after such individual's death but only if (A) proceedings for the adoption of the child had been instituted by such individual before his death, or (B) such child was adopted by such individual's surviving spouse before the end of two years after (i) the day on which such individual died or (ii) the date of enactment of the Social Security Amendments of 1958.[387] For purposes of clause (2), a person who is not the stepchild of an individual shall be deemed the stepchild of such individual if such individual was not the mother or adopting mother or the father or adopting father of such person and such individual and the mother or adopting mother, or the father or adopting father, as the case may be, of such person went through a marriage ceremony resulting in a purported marriage between them which, but for a legal impediment described in the last sentence of subsection (h)(1)(B), would have been a valid marriage. For purposes of clause (2), a child shall be deemed to have been the stepchild of an individual for a period of one year throughout the month in which occurs the expiration of such one year. For purposes of clause (3), a person shall be deemed to have no natural or adoptive parent living (other than a parent who was under a disability) throughout the most recent month in which a natural or adoptive parent (not under a disability) dies.

Husband

(f)The term "husband" means the husband of an individual, but only if (1) he is the father of her son or daughter, (2) he was married to her for a period of not less than one year immediately preceding the day on which his application is filed, or (3) in the month prior to the month of his marriage to her (A) he was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (c), (f) or (h) of section 202, (B) he had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (subject, however, to section 202(s)), or (C) he was entitled to, or upon application therefor and attainment of the required age (if any) he would have been entitled to, a widower's, child's (after attainment of age 18), or parent's insurance annuity under section 2 of the Railroad Retirement Act of 1974[388], as amended. For purposes of clause (2), a husband shall be deemed to have been married to an individual for a period of one year throughout the month in which occurs the first anniversary of his marriage to her. For purposes of subparagraph (C) of section 202(c)(1), a divorced husband shall be deemed not to be married throughout the month which he becomes divorced.

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[386] P.L. 101-508, §5104(a)(1), struck out "at the time of such individual's death living in such individual's household" and substituted "either living with or receiving at least one- half of his support from such individual at the time of such individual's death", applicable to benefits payable for months after December 1990, but only on the basis of applications filed after December 31, 1990.

[387] August 28, 1958 [P.L. 85-840; 72 Stat. 1013].

P.L. 101-508, §5104(a)(2), struck out "; except that this sentence shall not apply if at the time of such individual's death such person was receiving regular contributions toward his support from someone other than such individual or his spouse, or from any public or private welfare organization which furnishes services or assistance for children.", and substituted a period, applicable to benefits payable for months after December 1990, but only on the basis of applications filed after December 31, 1990.

Widower

(g)The term "widower" (except when used in the first sentence of section 202(i)) means the surviving husband of an individual, but only if (1) he is the father of her son or daughter, (2) he legally adopted her son or daughter while he was married to her and while such son or daughter was under the age of eighteen, (3) she legally adopted his son or daughter while he was married to her and while such son or daughter was under the age of eighteen, (4) he was married to her at the time both of them legally adopted a child under the age of eighteen, (5) he was married to her for a period of not less than nine months immediately prior to the day on which she died, or (6) in the month before the month of his marriage to her (A) he was entitled to, or on application therefor and attainment of age 62 in such prior month would have been entitled to, benefits under subsection (c), (f) or (h) of section 202, (B) he had attained age eighteen and was entitled to, or on application therefor would have been entitled to, benefits under subsection (d) of such section (subject, however, to section 202(s)), or (C) he was entitled to, or on application therefor and attainment of the required age (if any) he would have been entitled to, a widower's, child's (after attainment of age 18), or parent's insurance annuity under section 2 of the Railroad Retirement Act of 1974[389], as amended.

Determination of Family Status

(h)(1)(A)(i)[390] An applicant is the wife, husband, widow, or widower of a fully or currently insured individual for purposes of this title if the courts of the State in which such insured individual is domiciled at the time such applicant files an application, or, if such insured individual is dead, the courts of the State in which he was domiciled at the time of death, or, if such insured individual is or was not so domiciled in any State, the courts of the District of Columbia, would find that such applicant and such insured individual were validly married at the time such applicant files such application or, if such insured individual is dead, at the time he died.

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[388] P.L. 75-162 [as amended by P.L. 93-445] .

[389] P.L. 75-162 [as amended by P.L. 93-445] .

[390] P.L. 101-508, §5119(a)(1)(A), inserted "(i)".

(ii) If[391] such courts would not find that such applicant and such insured individual were validly married at such time, such applicant shall, nevertheless be deemed to be the wife, husband, widow, or widower, as the case may be, of such insured individual if such applicant would, under the laws applied by such courts in determining the devolution of intestate personal property, have the same status with respect to the taking of such property as a wife, husband, widow, or widower of such insured individual.

(B)(i)[392] In any case where under subparagraph (A) an applicant is not (and is not deemed to be) the wife, widow, husband, or widower of a fully or currently insured individual, or where under subsection (b), (c), (d), (f), or (g) such applicant is not the wife, divorced wife, widow, surviving divorced wife, husband, divorced husband, widower, or surviving divorced husband of such individual[393], but it is established to the satisfaction of the Secretary that such applicant in good faith went through a marriage ceremony with such individual resulting in a purported marriage between them which, but for a legal impediment not known to the applicant at the time of such ceremony, would have been a valid marriage,[394] then, for purposes of subparagraph (A) and subsections (b), (c), (d), (f), and (g)[395], such purported marriage shall be deemed to be a valid marriage. Notwithstanding the preceding sentence, in the case of any person who would be deemed under the preceding sentence a wife, widow, husband, or widower of the insured individual, such marriage shall not be deemed to be a valid marriage unless the applicant and the insured individual were living in the same household at the time of the death of the insured individual or (if the insured individual is living) at the time the applicant files the application.[396] A marriage that is deemed to be a valid marriage by reason of the preceding sentence shall continue to be deemed a valid marriage if the insured individual and the person entitled to benefits as the wife or husband of the insured individual are no longer living in the same household at the time of the death of such insured individual.[397]

(ii) The provisions of clause (i)[398] shall not apply[399] if the Secretary determines, on the basis of information brought to his attention, that such applicant entered into such purported marriage with such insured individual with knowledge that it would not be a valid marriage.

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[391] P.L. 101-508, §5119(a)(1)(B), struck out "If" and substituted "(ii) If", applicable to benefits for months after December 1990. See Vol. II, P.L. 101-508, §5119(e)(2), with respect to the application requirement.

[392] P.L. 101-508, §5119(a)(2)(A), inserted "(i)".

[393] P.L. 101-508, §5119(b)(1), struck out "(f), or (g) such applicant is not the wife, widow, husband, or widower of such individual" and substituted "(d), (f), or (g) such applicant is not the wife, divorced wife, widow, surviving divorced wife, husband, divorced husband, widower, or surviving divorced husband of such individual", applicable to benefits for months after December 1990. See Vol. II, P.L. 101- 508, §5119(e)(2), with respect to the application requirement.

[394] P.L. 101-508, §5119(b)(2), struck out "and such applicant and the insured individual were living in the same household at the time of the death of such insured individual or (if such insured individual is living) at the time such applicant files the application,", applicable to benefits for months after December 1990. See Vol. II, P.L. 101-508, §5119(e)(2), with respect to the application requirement.

[395] P.L. 101-508, §5119(b)(3), struck out "(f), and (g)" and substituted "(d), (f), and (g)", applicable to benefits for months after December 1990. See Vol. II, P.L. 101-508, §5119(e)(2), with respect to the application requirement.

[396] P.L. 101-508, §5119(b)(4), added this sentence, applicable to benefits for months after December 1990. See Vol. II, P.L. 101-508, §5119(e)(2), with respect to the application requirement.

[397] P.L. 101-508, §5119(b)(4), added this sentence, applicable to benefits for months after December 1990. See Vol. II, P.L. 101-508, §5119(e)(2), with respect to the application requirement.

[398] P.L. 101-508, §5119(a)(2)(B), struck out "The provisions of the preceding sentence" and substituted "(ii) The provisions of clause (i)", applicable to benefits for months after December 1990. See Vol. II, P.L. 101-508, §5119(e)(2), with respect to the application requirement.

[399] P.L. 101-508, §5119(a)(2)(C), struck out " (i) if another person is or has been entitled to a benefit under subsection (b), (c), (e), (f), or (g) of section 202 on the basis of the wages and self-employment income of such insured individual and such other person is (or is deemed to be) a wife, widow, husband, or widower of such insured individual under subparagraph (A) at the time such applicant

(iii)[400] The entitlement to a monthly benefit under subsection (b), or (c)[401] of section 202, based on the wages and self-employment income of such insured individual, of a person who would not be deemed to be a wife or husband[402] of such insured individual but for this subparagraph, shall end with the month before the month in which such person enters[403] into a marriage, valid without regard to this subparagraph, with a person other than such insured individual.

(iv)[404] For purposes of this subparagraph, a legal impediment to the validity of a purported marriage includes only an impediment (I)[405] resulting from the lack of dissolution of a previous marriage or otherwise arising out of such previous marriage or its dissolution, or (II)[406] resulting from a defect in the procedure followed in connection with such purported marriage.

(2)(A) In determining whether an applicant is the child or parent of a fully or currently insured individual for purposes of this title, the Secretary shall apply such law as would be applied in determining the devolution of intestate personal property by the courts of the State in which such insured individual is domiciled at the time such applicant files application, or, if such insured individual is dead, by the courts of the State in which he was domiciled at the time of his death, or, if such insured individual is or was not so domiciled in any State, by the courts of the District of Columbia. Applicants who according to such law would have the same status relative to taking intestate personal property as a child or parent shall be deemed such.

(B) If an applicant is a son or daughter of a fully or currently insured individual but is not (and is not deemed to be) the child of such insured individual under subparagraph (A), such applicant shall nevertheless be deemed to be the child of such insured individual if such insured individual and the mother or father, as the case may be, of such applicant went through a marriage ceremony resulting in a purported marriage between them which, but for a legal impediment described in the last sentence of paragraph (1)(B), would have been a valid marriage.

(3)An applicant who is the son or daughter of a fully or currently insured individual, but who is not (and is not deemed to be) the child

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files the application, or (ii)”, applicable to benefits for months after December 1990. See Vol. II, P.L. 101-508, §5119(e)(2), with respect to the application requirement.

[400] P.L. 101- 508, §5119(a)(2)(D), inserted “(iii)”.

[401] P.L. 101-508, §5119(a)(2)(E), struck out “, (c), (e), (f), or (g)” and substituted “or (c)”. See Vol. II, P.L. 101-508, §5119(e)(2), with respect to the application requirement.

[402] P.L. 101-508, §5119(a)(2)(F), struck out “, widow, husband, or widower” and substituted “or husband”, applicable to benefits for months after December 1990. See Vol. II, P.L. 101- 508, §5119(e)(2), with respect to the application requirement.

[403] P.L. 101-508, §5119(a)(2)(G), struck out “(i) in which the Secretary certifies, pursuant to section 205(i), that another person is entitled to a benefit under subsection (b), (c), (e), (f), or (g) of section 202 on the basis of the wages and self-employment income of such insured individual, if such other person is (or is deemed to be) the wife, widow, husband, or widower of such insured individual under subparagraph (A), or (ii) if the applicant is entitled to a monthly benefit under subsection (b) or (c) of section 202, in which such applicant entered” and substituted “in which such person enters”, applicable to benefits for months after December 1990. See Vol. II, P.L. 101-508, §5119(e)(2), with respect to the application requirement.

[404] P.L. 101-508, §5119(a)(2)(H), inserted “(iv)”.

[405] P.L. 101-508, §5119(a)(2)(I), struck out “(i)” and substituted “(I)”.

[406] P.L. 101-508, §5119(a)(2)(I), struck out “(ii)” and substituted “(II)”.

of such insured individual under paragraph (2), shall nevertheless be deemed to be the child of such insured individual if:

(A) in the case of an insured individual entitled to old-age insurance benefits (who was not, in the month preceding such entitlement, entitled to disability insurance benefits)—

(i) such insured individual—

(I) has acknowledged in writing that the applicant is his or her son or daughter,

(II) has been decreed by a court to be the mother or father of the applicant, or

(III) has been ordered by a court to contribute to the support of the applicant because the applicant is his or her son or daughter,

and such acknowledgment, court decree, or court order was made not less than one year before such insured individual became entitled to old-age insurance benefits or attained retirement age (as defined in subsection (l)), whichever is earlier; or

(ii) such insured individual is shown by evidence satisfactory to the Secretary to be the mother or father of the applicant and was living with or contributing to the support of the applicant at the time such applicant's application for benefits was filed;

(B) in the case of an insured individual entitled to disability insurance benefits, or who was entitled to such benefits in the month preceding the first month for which he or she was entitled to old-age insurance benefits—

(i) such insured individual—

(I) has acknowledged in writing that the applicant is his or her son or daughter,

(II) has been decreed by a court to be the mother or father of the applicant, or

(III) has been ordered by a court to contribute to the support of the applicant because the applicant is his or her son or daughter,

and such acknowledgment, court decree, or court order was made before such insured individual's most recent period of disability began; or

(ii) such insured individual is shown by evidence satisfactory to the Secretary to be the mother or father of the applicant and was living with or contributing to the support of that applicant at the time such applicant's application for benefits was filed;

(C) in the case of a deceased individual—

(i) such insured individual—

(I) had acknowledged in writing that the applicant is his or her son or daughter,

(II) had been decreed by a court to be the mother or father of the applicant, or

(III) had been ordered by a court to contribute to the support of the applicant because the applicant was his or her son or daughter,

and such acknowledgment, court decree, or court order was made before the death of such insured individual, or

(ii) such insured individual is shown by evidence satisfactory to the Secretary to have been the mother or father of the applicant, and such insured individual was living with or contributing to the support of the applicant at the time such insured individual died.

For purposes of subparagraphs (A)(i) and (B)(i), an acknowledgement, court decree, or court order shall be deemed to have occurred on the first day of the month in which it actually occurred.

Disability; Period of Disability

(i)(1) Except for purposes of sections 202(d), 202(e), 202(f), 223, and 225, the term "disability" means (A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months, or (B) blindness; and the term "blindness" means central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered for purposes of this paragraph as having a central visual acuity of 20/200 or less. The provisions of paragraphs (2)(A), (2)(B)[407], (3), (4), (5), and (6) of section 223(d) shall be applied for purposes of determining whether an individual is under a disability within the meaning of the first sentence of this paragraph in the same manner as they are applied for purposes of paragraph (1) of such section. Nothing in this title shall be construed as authorizing the Secretary or any other officer or employee of the United States to interfere in any way with the practice of medicine or with relationships between practitioners of medicine and their patients, or to exercise any supervision or control over the administration or operation of any hospital.

(2)(A) The term "period of disability" means a continuous period (beginning and ending as hereinafter provided in this subsection) during which an individual was under a disability (as defined in paragraph (1)), but only if such period is of not less than five full calendar months' duration or such individual was entitled to benefits under section 223 for one or more months in such period.

(B) No period of disability shall begin as to any individual unless such individual files an application for a disability determination with respect to such period; and no such period shall begin as to any individual after such individual attains retirement age (as defined in subsection (l)). In the case of a deceased individual, the requirement of an application under the preceding sentence may be satisfied by an application for a disability determination filed with respect to such individual within 3 months after the month in which he died.

(C) A period of disability shall begin—

(i) on the day the disability began, but only if the individual satisfies the requirements of paragraph (3) on such day; or

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[407] P.L. 101-508, §5103(b)(1), struck out "(C)" and substituted "(B)", applicable to monthly insurance benefits for months after December 1990 for which applications are filed on or after January 1, 1991, or are pending on such date.

(ii) if such individual does not satisfy the requirements of paragraph (3) on such day, then on the first day of the first quarter thereafter in which he satisfies such requirements.

(D) A period of disability shall end with the close of whichever of the following months is the earlier: (i) the month preceding the month in which the individual attains retirement age (as defined in subsection (l)), or (ii) the month preceding (I) the termination month (as defined in section 223(a)(1)), or, if earlier (II) the first month for which no benefit is payable by reason of section 223(e), where no benefit is payable for any of the succeeding months during the 36-month period referred to in such section. The provisions set forth in section 223(f) with respect to determinations of whether entitlement to benefits under this title or title XVIII based on the disability of any individual is terminated (on the basis of a finding that the physical or mental impairment on the basis of which such benefits are provided has ceased, does not exist, or is not disabling) shall apply in the same manner and to the same extent with respect to determinations of whether a period of disability has ended (on the basis of a finding that the physical or mental impairment on the basis of which the finding of disability was made has ceased, does not exist, or is not disabling).

(E) Except as is otherwise provided in subparagraph (F), no application for a disability determination which is filed more than 12 months after the month prescribed by subparagraph (D) as the month in which the period of disability ends (determined without regard to subparagraph (B) and this subparagraph) shall be accepted as an application for purposes of this paragraph.

(F) An application for a disability determination which is filed more than 12 months after the month prescribed by subparagraph (D) as the month in which the period of disability ends (determined without regard to subparagraphs (B) and (E)) shall be accepted as an application for purposes of this paragraph if—

(i) in the case of an application filed by or on behalf of an individual with respect to a disability which ends after the month in which the Social Security Amendments of 1967 is enacted[408], such application is filed not more than 36 months after the month in which such disability ended, such individual is alive at the time the application is filed, and the Secretary finds in accordance with regulations prescribed by him that the failure of such individual to file an application for a disability determination within the time specified in subparagraph (E) was attributable to a physical or mental condition of such individual which rendered him incapable of executing such an application, and

(ii) in the case of an application filed by or on behalf of an individual with respect to a period of disability which ends in or before the month in which the Social Security Amendments of 1967 is enacted—

(I) such application is filed not more than 12 months after the month in which the Social Security Amendments of 1967 is enacted,

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[408] January 1968 [P.L. 90-248; 81 Stat. 821].

(II) a previous application for a disability determination has been filed by or on behalf of such individual (1) in or before the month in which the Social Security Amendments of 1967 is enacted[409], and (2) not more than 36 months after the month in which his disability ended, and

(III) the Secretary finds in accordance with regulations prescribed by him, that the failure of such individual to file an application within the then specified time period was attributable to a physical or mental condition of such individual which rendered him incapable of executing such an application.

In making a determination under this subsection, with respect to the disability or period of disability of any individual whose application for a determination thereof is accepted solely by reason of the provisions of this subparagraph (F), the provisions of this subsection (other than the provisions of this subparagraph) shall be applied as such provisions are in effect at the time such determination is made.

(G) An application for a disability determination filed before the first day on which the applicant satisfies the requirements for a period of disability under this subsection shall be deemed a valid application (and shall be deemed to have been filed on such first day) only if the applicant satisfies the requirements for a period of disability before the Secretary makes a final decision on the application and no request under section 205(b) for notice and opportunity for a hearing thereon is made or, if such a request is made, before a decision based upon the evidence adduced at the hearing is made (regardless of whether such decision becomes the final decision of the Secretary).

(3) The requirements referred to in clauses (i) and (ii) of paragraph (2)(C) are satisfied by an individual with respect to any quarter only if—

(A) he would have been a fully insured individual (as defined in section 214) had he attained age 62 and filed application for benefits under section 202(a) on the first day of such quarter; and

(B)(i) he had not less than 20 quarters of coverage during the 40-quarter period which ends with such quarter, or

(ii) if such quarter ends before he attains (or would attain) age 31, not less than one-half (and not less than 6) of the quarters during the period ending with such quarter and beginning after he attained the age of 21 were quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter were quarters of coverage, or

(iii) in the case of an individual (not otherwise insured under clause (i)) who, by reason of clause (ii), had a prior period of disability that began during a period before the quarter in which he or she attained age 31, not less than one-half of the quarters beginning after such individual attained age 21 and ending with such quarter are quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter are quarters of coverage;

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[409] January 1968 [P.L. 90-248; 81 Stat. 821].

except that the provisions of subparagraph (B) of this paragraph shall not apply in the case of an individual who is blind (within the meaning of "blindness" as defined in paragraph (1)). For purposes of subparagraph (B) of this paragraph, when the number of quarters in any period is an odd number, such number shall be reduced by one, and a quarter shall not be counted as part of any period if any part of such quarter was included in a prior period of disability unless such quarter was a quarter of coverage.

Periods of Limitation Ending on Nonwork Days

(j) Where this title, any provision of another law of the United States (other than the Internal Revenue Code of 1954[410]) relating to or changing the effect of this title, or any regulation issued by the Secretary pursuant thereto provides for a period within which an act is required to be done which affects eligibility for or the amount of any benefit or payment under this title or is necessary to establish or protect any rights under this title, and such period ends on a Saturday, Sunday, or legal holiday, or on any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order, then such act shall be considered as done within such period if it is done on the first day thereafter which is not a Saturday, Sunday, or legal holiday or any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order. For purposes of this subsection, the day on which a period ends shall include the day on which an extension of such period, as authorized by law or by the Secretary pursuant to law, ends. The provisions of this subsection shall not extend the period during which benefits under this title may (pursuant to section 202(j)(1) or 223(b)) be paid for months prior to the day application for such benefits is filed, or during which an application for benefits under this title may (pursuant to section 202(j)(2) or 223(b)) be accepted as such.

Waiver of Nine-Month Requirement for Widow, Stepchild, or Widower in Case of Accidental Death or in Case of Serviceman Dying in Line of Duty, or in Case of Remarriage to the Same Individual

(k) The requirement in clause (5) of subsection (c) or clause (5) of subsection (g) that the surviving spouse of an individual have been married to such individual for a period of not less than nine months immediately prior to the day on which such individual died in order to qualify as such individual's widow or widower, and the requirement in subsection (e) that the stepchild of a deceased individual have been such stepchild for not less than nine months immediately preceding the day on which such individual died in order to qualify as such individual's child, shall be deemed to be satisfied, where such individual dies within the applicable nine-month period, if—

(1) his death—

(A) is accidental, or

(B) occurs in line of duty while he is a member of a uniformed service serving on active duty (as defined in section 210(l)(2)), unless the Secretary determines that at the time of the marriage involved the individual could not have reasonably been expected to live for nine months, or

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[410] P.L. 83-591.

(2)(A) the widow or widower of such individual had been previously married to such individual and subsequently divorced and such requirement would have been satisfied at the time of such divorce if such previous marriage had been terminated by the death of such individual at such time instead of by divorce; or

(B) the stepchild of such individual had been the stepchild of such individual during a previous marriage of such stepchild's parent to such individual which ended in divorce and such requirement would have been satisfied at the time of such divorce if such previous marriage had been terminated by the death of such individual at such time instead of by divorce;

except that paragraph (2) of this subsection shall not apply if the Secretary determines that at the time of the marriage involved the individual could not have reasonably been expected to live for nine months. For purposes of paragraph (1)(A) of this subsection, the death of an individual is accidental if he receives bodily injuries solely through violent, external, and accidental means and, as a direct result of the bodily injuries and independently of all other causes, loses his life not later than three months after the day on which he receives such bodily injuries.

Retirement Age

(l)(1) The term "retirement age" means—

(A) with respect to an individual who attains early retirement age (as defined in paragraph (2)) before January 1, 2000, 65 years of age;

(B) with respect to an individual who attains early retirement age after December 31, 1999, and before January 1, 2005, 65 years of age plus the number of months in the age increase factor (as determined under paragraph (3)) for the calendar year in which such individual attains early retirement age;

(C) with respect to an individual who attains early retirement age after December 31, 2004, and before January 1, 2017, 66 years of age;

(D) with respect to an individual who attains early retirement age after December 31, 2016, and before January 1, 2022, 66 years of age plus the number of months in the age increase factor (as determined under paragraph (3)) for the calendar year in which such individual attains early retirement age; and

(E) with respect to an individual who attains early retirement age after December 31, 2021, 67 years of age.

(2) The term "early retirement age" means age 62 in the case of an old-age, wife's, or husband's insurance benefit, and age 60 in the case of a widow's or widower's insurance benefit.

(3) The age increase factor for any individual who attains early retirement age in a calendar year within the period to which subparagraph (B) or (D) of paragraph (1) applies shall be determined as follows:

(A) With respect to an individual who attains early retirement age in the 5-year period consisting of the calendar years 2000 through 2004, the age increase factor shall be equal to two-twelfths of the number of months in the period beginning with January 2000 and ending with December of the year in which the individual attains early retirement age.

(B) With respect to an individual who attains early retirement age in the 5-year period consisting of the calendar years 2017 through 2021, the age increase factor shall be equal to two-twelfths of the number of months in the period beginning with January 2017 and ending with December of the year in which the individual attains early retirement age.

BENEFITS IN CASE OF VETERANS

SEC. 217. [42 U.S.C. 417] (a)(1) For purposes of determining entitlement to and the amount of any monthly benefit for any month after August 1950, or entitlement to and the amount of any lump-sum death payment in case of a death after such month, payable under this title on the basis of the wages and self-employment income of any World War II veteran, and for purposes of section 216(i)(3), such veteran shall be deemed to have been paid wages (in addition to the wages, if any, actually paid to him) of $160 in each month during any part of which he served in the active military or naval service of the United States during World War II. This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application; or

(B) a benefit (other than a benefit payable in a lump sum unless it is a commutation of, or a substitute for, periodic payments) which is based, in whole or in part, upon the active military or naval service of such veteran during World War II is determined by any agency or wholly owned instrumentality of the United States (other than the Veterans' Administration) to be payable by it under any other law of the United States or under a system established by such agency or instrumentality.

The provisions of clause (B) shall not apply in the case of any monthly benefit or lump-sum death payment under this title if its application would reduce by $0.50 or less the primary insurance amount (as computed under section 215 prior to any recomputation thereof pursuant to subsection (f) of such section) of the individual on whose wages and self-employment income such benefit or payment is based. The provisions of clause (B) shall also not apply for purposes of section 216(i)(3).

(2) Upon application for benefits or a lump-sum death payment on the basis of the wages and self-employment income of any World War II veteran, the Secretary shall make a decision without regard to clause (B) of paragraph (1) of this subsection unless he has been notified by some other agency or instrumentality of the United States that, on the basis of the military or naval service of such veteran during World War II, a benefit described in clause (B) of paragraph (1) has been determined by such agency or instrumentality to be payable by it. If he has not been so notified, the Secretary shall then ascertain whether some other agency or wholly owned

instrumentality of the United States has decided that a benefit described in clause (B) of paragraph (1) is payable by it. If any such agency or instrumentality has decided, or thereafter decides, that such a benefit is payable by it, it shall so notify the Secretary, and the Secretary shall certify no further benefits for payment or shall recompute the amount of any further benefits payable, as may be required by paragraph (1) of this subsection.

(3) Any agency or wholly owned instrumentality of the United States which is authorized by any law of the United States to pay benefits, or has a system of benefits which are based, in whole or in part, on military or naval service during World War II shall, at the request of the Secretary, certify to him, with respect to any veteran, such information as the Secretary deems necessary to carry out his functions under paragraph (2) of this subsection.

(b)(1) Subject to paragraph (3), any[411] World War II veteran who died during the period of three years immediately following his separation from the active military or naval service of the United States shall be deemed to have died a fully insured individual whose primary insurance amount is the amount determined under section 215(c) as in effect in December 1978. Notwithstanding section 215(d) as in effect in December 1978, the primary insurance benefit (for purposes of section 215(c) as in effect in December 1978) of such veteran shall be determined as provided in this title as in effect prior to the enactment of this section[412], except that the 1 per centum addition provided for in section 209(a)(4)(B)[413] of this Act as in effect prior to the enactment of this section shall be applicable only with respect to calendar years prior to 1951. This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application;

(B) any pension or compensation is determined by the Veterans' Administration to be payable by it on the basis of the death of such veteran;

(C) the death of the veteran occurred while he was in the active military or naval service of the United States; or

(D) such veteran has been discharged or released from the active military or naval service of the United States subsequent to July 26, 1951.

(2) Upon an application for benefits or a lump-sum death payment on the basis of the wages and self-employment income of any World War II veteran, the Secretary shall make a decision without regard to paragraph (1)(B) of this subsection unless he has been notified by the Veterans' Administration that pension or compensation is determined to be payable by the Veterans' Administration by reason of the death of such veteran. The Secretary shall thereupon report such decision to the Veterans' Administration. If the Veterans' Administration in any such case has made an adjudication or thereafter makes an adjudication that any pension or compensation is payable under any law administered by it, it shall notify the Secretary, and

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[411] P.L. 101-508, §5117(b)(1), struck out "Any" and substituted "Subject to paragraph (3), any", effective November 5, 1990.

[412] August 28, 1950 [P.L. 81-734; 64 Stat. 477].

[413] P.L. 101-239, §10208(d)(2)(A)(iv), struck out "(e)(2)" and substituted "(a)(4)(B)", effective December 19, 1989.

the Secretary shall certify no further benefits for payment, or shall recompute the amount of any further benefits payable, as may be required by paragraph (1) of this subsection. Any payments theretofore certified by the Secretary on the basis of paragraph (1) of this subsection to any individual, not exceeding the amount of any accrued pension or compensation payable to him by the Veterans' Administration, shall (notwithstanding the provisions of section 3101 of title 38, United States Code) be deemed to have been paid to him by such Administration on account of such accrued pension or compensation. No such payment certified by the Secretary, and no payment certified by him for any month prior to the first month for which any pension or compensation is paid by the Veterans' Administration shall be deemed by reason of this subsection to have been an erroneous payment.

(3)(A) The preceding provisions of this subsection shall apply for purposes of determining the entitlement to benefits under section 202, based on the primary insurance amount of the deceased World War II veteran, of any surviving individual only if such surviving individual makes application for such benefits before the end of the 18-month period after the month in which the Omnibus Budget Reconciliation Act of 1990 was enacted.

(B) Subparagraph (A) shall not apply if any person is entitled to benefits under section 202 based on the primary insurance amount of such veteran for the month preceding the month in which such application is made.[414]

(c) In the case of any World War II veteran to whom subsection (a) is applicable, proof of support required under section 202(h) may be filed by a parent at any time prior to July 1951 or prior to the expiration of two years after the date of the death of such veteran, whichever is the later.

(d) For the purposes of this section—

(1) The term "World War II" means the period beginning with September 16, 1940, and ending at the close of July 24, 1947.

(2) The term "World War II veteran" means any individual who served in the active military or naval service of the United States at any time during World War II and who, if discharged or released therefrom, was so discharged or released under conditions other than dishonorable after active service of ninety days or more or by reason of a disability or injury incurred or aggravated in service in line of duty; but such term shall not include any individual who died while in the active military or naval service of the United States if his death was inflicted (other than by an enemy of the United States) as lawful punishment for a military or naval offense.

(e)(1) For purposes of determining entitlement to and the amount of any monthly benefit or lump-sum death payment payable under this title on the basis of wages and self-employment income of any veteran (as defined in paragraph (4)), and for purposes of section 216(i)(3), such veteran shall be deemed to have been paid wages (in addition to the wages, if any, actually paid to him) of $160 in each month during any part of which he served in the active military or naval service of the United States on or after July 25, 1947, and prior to January 1, 1957. This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

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[414] P.L. 101-508, §5117(b)(2), added paragraph (3), effective November 5, 1990.

(A) a larger such benefit or payment, as the case may be, would be payable without its application; or

(B) a benefit (other than a benefit payable in a lump sum unless it is a commutation of, or a substitute for, periodic payments) which is based, in whole or in part, upon the active military or naval service of such veteran on or after July 25, 1947, and prior to January 1, 1957, is determined by any agency or wholly owned instrumentality of the United States (other than the Veterans' Administration) to be payable by it under any other law of the United States or under a system established by such agency or instrumentality.

The provisions of clause (B) shall not apply in the case of any monthly benefit or lump-sum death payment under this title if its application would reduce by $0.50 or less the primary insurance amount (as computed under section 215 prior to any recomputation thereof pursuant to subsection (f) of such section) of the individual on whose wages and self-employment income such benefit or payment is based. The provisions of clause (B) shall also not apply for purposes of section 216(i)(3). In the case of monthly benefits under this title for months after December 1956 (and any lump-sum death payment under this title with respect to a death occurring after December 1956) based on the wages and self-employment income of a veteran who performed service (as a member of a uniformed service) to which the provisions of section 210(l)(1) are applicable, wages which would, but for the provisions of clause (B), be deemed under this subsection to have been paid to such veteran with respect to his active military or naval service performed after December 1950 shall be deemed to have been paid to him with respect to such service notwithstanding the provisions of such clause, but only if the benefits referred to in such clause which are based (in whole or in part) on such service are payable solely by the Army, Navy, Air Force, Marine Corps, Coast Guard[415], Coast and Geodetic Survey, National Oceanic and Atmospheric Administration Corps, or Public Health Service[416].

(2) Upon application for benefits or a lump-sum death payment on the basis of the wages and self-employment income of any veteran, the Secretary shall make a decision without regard to clause (B) of paragraph (1) of this subsection unless he has been notified by some other agency or instrumentality of the United States that, on the basis of the military or naval service of such veteran on or after July 25, 1947, and prior to January 1, 1957, a benefit described in clause (B) of paragraph (1) has been determined by such agency or instrumentality to be payable by it. If he has not been so notified, the Secretary shall then ascertain whether some other agency or wholly owned instrumentality of the United States has decided that a benefit described in clause (B) of paragraph (1) is payable by it. If any such agency or instrumentality has decided, or thereafter decides, that such a benefit is payable by it, it shall so notify the Secretary, and the Secretary shall certify no further benefits for payment or shall recompute the amount of any further benefits payable, as may be required by paragraph (1) of this subsection.

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[415] Department of Transportation.

[416] Department of Health and Human Services.

(3) Any agency or wholly owned instrumentality of the United States which is authorized by any law of the United States to pay benefits, or has a system of benefits which are based, in whole or in part, on military or naval service on or after July 25, 1947, and prior to January 1, 1957, shall, at the request of the Secretary, certify to him, with respect to any veteran, such information as the Secretary deems necessary to carry out his functions under paragraph (2) of this subsection.

(4) For the purposes of this subsection, the term "veteran" means any individual who served in the active military or naval service of the United States at any time on or after July 25, 1947, and prior to January 1, 1957, and who, if discharged or released therefrom, was so discharged or released under conditions other than dishonorable after active service of ninety days or more or by reason of a disability or injury incurred or aggravated in service in line of duty; but such term shall not include any individual who died while in the active military or naval service of the United States if his death was inflicted (other than by an enemy of the United States) as lawful punishment for a military or naval offense.

(f)(1) In any case where a World War II veteran (as defined in subsection (d)(2)) or a veteran (as defined in subsection (e)(4)) has died or shall hereafter die, and his or her surviving spouse or child is entitled under subchapter III of chapter 83 of title 5, United States Code, to an annuity in the computation of which his or her active military or naval service was included, clause (B) of subsection (a)(1) or clause (B) of subsection (e)(1) shall not operate (solely by reason of such annuity) to make such subsection inapplicable in the case of any monthly benefit under section 202 which is based on his or her wages and self-employment income; except that no such surviving spouse or child shall be entitled under section 202 to any monthly benefit in the computation of which such service is included by reason of this subsection (A) unless such surviving spouse or child after December 1956 waives his or her right to receive such annuity, or (B) for any month prior to the first month with respect to which the Director of the Office of Personnel Management certifies to the Secretary that (by reason of such waiver) no further annuity will be paid to such surviving spouse or child under such subchapter III on the basis of such veteran's military or civilian service. Any such waiver shall be irrevocable.

(2) Whenever a surviving spouse waives his or her right to receive such annuity such waiver shall constitute a waiver on his or her own behalf; a waiver by a legal guardian or guardians, or, in the absence of a legal guardian, the person (or persons) who has the child in his or her care, of the child's right to receive such annuity shall constitute a waiver on behalf of such child. Such a waiver with respect to an annuity based on a veteran's service shall be valid only if the surviving spouse and all children, or, if there is no surviving spouse, all the children, waive their rights to receive annuities under subchapter III of chapter 83 of title 5, United States Code, based on such veteran's military or civilian service.

Appropriation to Trust Funds

(g)(1) Within thirty days after the date of the enactment of the Social Security Amendments of 1983[417], the Secretary shall determine the amount equal to the excess of—

(A) the actuarial present value as of such date of enactment of the past and future benefit payments from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and the Federal Hospital Insurance Trust Fund under this title and title XVIII, together with associated administrative costs, resulting from the operation of this section (other than this subsection) and section 210 of this Act as in effect before the enactment of the Social Security Amendments of 1950[418], over

(B) any amounts previously transferred from the general fund of the Treasury to such Trust Funds pursuant to the provisions of this subsection as in effect immediately before the date of the enactment of the Social Security Amendments of 1983[419].

Such actuarial present value shall be based on the relevant actuarial assumptions set forth in the report of the Board of Trustees of each such Trust Fund for 1983 under sections 201(c) and 1817(b). Within thirty days after the date of the enactment of the Social Security Amendments of 1983, the Secretary of the Treasury shall transfer the amount determined under this paragraph with respect to each such Trust Fund to such Trust Fund from amounts in the general fund of the Treasury not otherwise appropriated.

(2) The Secretary shall revise the amount determined under paragraph (1) with respect to each such Trust Fund in 1985 and each fifth year thereafter, as determined appropriate by the Secretary from data which becomes available to him after the date of the determination under paragraph (1) on the basis of the amount of benefits and administrative expenses actually paid from such Trust Fund under this title or title XVIII and the relevant actuarial assumptions set forth in the report of the Board of Trustees of such Trust Fund for such year under section 201(c) or 1817(b). Within 30 days after any such revision, the Secretary of the Treasury, to the extent provided in advance in appropriation Acts, shall transfer to such Trust Fund, from amounts in the general fund of the Treasury not otherwise appropriated, or from such Trust Fund to the general fund of the Treasury, such amounts as the Secretary of the Treasury determines necessary to take into account such revision.

(h)(1) For the purposes of this section, any individual who the Secretary finds—

(A) served during World War II (as defined in subsection (d)(1)) in the active military or naval service of a country which was on September 16, 1940, at war with a country with which the United States was at war during World War II;

(B) entered into such active service on or before December 8, 1941;

(C) was a citizen of the United States throughout such period of service or lost his United States citizenship solely because of his entrance into such service;

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[417] April 20, 1983 [P.L. 98-21; 97 Stat. 65].

[418] August 28, 1950 [P.L. 81-734; 64 Stat. 477].

[419] April 20, 1983 [P.L. 98-21; 97 Stat. 65].

(D) had resided in the United States for a period or periods aggregating four years during the five-year period ending on the day of, and was domiciled in the United States on the day of, such entrance into such active service; and

(E)(i) was discharged or released from such service under conditions other than dishonorable after active service of ninety days or more or by reason of a disability or injury incurred or aggravated in service in line of duty, or

(ii) died while in such service,

shall be considered a World War II veteran (as defined in subsection (d)(2)) and such service shall be considered to have been performed in the active military or naval service of the United States.

(2) In the case of any individual to whom paragraph (1) applies, proof of support required under section 202(f) or (h) may be filed at any time prior to the expiration of two years after the date of such individual's death or the date of the enactment of this subsection[420], whichever is the later.

VOLUNTARY AGREEMENTS FOR COVERAGE OF STATE AND LOCAL EMPLOYEES[421]

Purpose of Agreement

SEC. 218. [42 U.S.C. 418] (a)(1) The Secretary shall, at the request of any State, enter into an agreement with such State for the purpose of extending the insurance system established by this title to services performed by individuals as employees of such State or any political subdivision thereof. Each such agreement shall contain such provisions, not inconsistent with the provisions of this section, as the State may request.

(2) Notwithstanding section 210(a), for the purposes of this title the term "employment" includes any service included under an agreement entered into under this section.

Definitions

(b) For the purposes of this section—

(1) The term "State" does not include the District of Columbia, Guam, or American Samoa.

(2) The term "political subdivision" includes an instrumentality of (A) a State, (B) one or more political subdivisions of a State, or (C) a State and one or more of its political subdivisions.

(3) The term "employee" includes an officer of a State or political subdivision.

(4) The term "retirement system" means a pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof.

(5) The term "coverage group" means (A) employees of the State other than those engaged in performing service in connection with a proprietary function; (B) employees of a political

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[420] August 28, 1958 [P.L. 85-840; 72 Stat. 1013].

[421] See Vol. II, P.L. 83-591, §6511(d)(5), with respect to a special period of limitation with respect to self-employment tax in certain cases.

See Vol. II, P.L. 99-272, §12114, with respect to coverage of Connecticut State Police.

See Vol. II, P.L. 100-203, §9008, with respect to modification of the agreement with Iowa to provide coverage for certain policemen and firemen.

subdivision of a State other than those engaged in performing service in connection with a proprietary function; (C) employees of a State engaged in performing service in connection with a single proprietary function; or (D) employees of a political subdivision of a State engaged in performing service in connection with a single proprietary function. If under the preceding sentence an employee would be included in more than one coverage group by reason of the fact that he performs service in connection with two or more proprietary functions or in connection with both a proprietary function and a nonproprietary function, he shall be included in only one such coverage group. The determination of the coverage group in which such employee shall be included shall be made in such manner as may be specified in the agreement. Persons employed under section 709 of title 32, United States Code, who elected under section 6 of the National Guard Technicians Act of 1968[422] to remain covered by an employee retirement system of, or plan sponsored by, a State or the Commonwealth of Puerto Rico, shall, for the purposes of this Act, be employees of the State or the Commonwealth of Puerto Rico and (notwithstanding the preceding provisions of this paragraph), shall be deemed to be a separate coverage group. For purposes of this section, individuals employed pursuant to an agreement, entered into pursuant to section 205 of the Agricultural Marketing Act of 1946[423] (7 U.S.C. 1624) or section 14 of the Perishable Agricultural Commodities Act, 1930[424] (7 U.S.C. 499n), between a State and the United States Department of Agriculture to perform services as inspectors of agricultural products may be deemed, at the option of the State, to be employees of the State and (notwithstanding the preceding provisions of this paragraph) shall be deemed to be a separate coverage group.[425]

Services Covered

(c)(1) An agreement under this section shall be applicable to any one or more coverage groups designated by the State.

(2) In the case of each coverage group to which the agreement applies, the agreement must include all services (other than services excluded by or pursuant to subsection (d) or paragraph (3), (5), or (6) of this subsection) performed by individuals as members of such group.

(3) Such agreement shall, if the State requests it, exclude (in the case of any coverage group) any one or more of the following:

(A) All services in any class or classes of (i) elective positions, (ii) part-time positions, or (iii) positions the compensation for which is on a fee basis;

(B) All services performed by individuals as members of a coverage group in positions covered by a retirement system on the date such agreement is made applicable to such coverage group, but only in the case of individuals who, on such date (or, if later, the date on which they first occupy such positions), are not eligible to become members of such system and whose services in such positions have not already been included under such agreement pursuant to subsection (d)(3).

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[422] P.L. 90-486.

[423] P.L. 79-733.

[424] P.L. 71-420.

[425] See Vol. II, P.L. 100-456, §523, with respect to Army National Guard civilian technicians.

(4) The Secretary shall, at the request of any State, modify the agreement with such State so as to (A) include any coverage group to which the agreement did not previously apply, or (B) include, in the case of any coverage group to which the agreement applies, services previously excluded from the agreement; but the agreement as so modified may not be inconsistent with the provisions of this section applicable in the case of an original agreement with a State. A modification of an agreement pursuant to clause (B) of the preceding sentence may apply to individuals to whom paragraph (3)(B) is applicable (whether or not the previous exclusion of the service of such individuals was pursuant to such paragraph), but only if such individuals are, on the effective date specified in such modification, ineligible to be members of any retirement system or if the modification with respect to such individuals is pursuant to subsection (d)(3).

(5) Such agreement shall, if the State requests it, exclude (in the case of any coverage group) any agricultural labor, or service performed by a student, designated by the State. This paragraph shall apply only with respect to service which is excluded from employment by any provision of section 210(a) other than paragraph (7) of such section and service the remuneration for which is excluded from wages by subparagraph (B) of section 209(a)(7)[426].

(6) Such agreement shall exclude—

(A) service performed by an individual who is employed to relieve him from unemployment,

(B) service performed in a hospital, home, or other institution by a patient or inmate thereof,

(C) covered transportation service (as determined under section 210(k)),

(D) service (other than agricultural labor or service performed by a student) which is excluded from employment by any provision of section 210(a) other than paragraph (7) of such section,[427]

(E) service performed by an individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency, and[428]

(F) service described in section 210(a)(7)(F) which is included as "employment" under section 210(a).[429]

(7) No agreement may be made applicable (either in the original agreement or by any modification thereof) to service performed by any individual to whom paragraph (3)(B) is applicable unless such agreement provides (in the case of each coverage group involved) either that the service of any individual to whom such paragraph is applicable and who is a member of such coverage group shall continue to be covered by such agreement in case he thereafter becomes eligible to be a member of a retirement system, or that such service shall cease to be so covered when he becomes eligible to be a

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[426] P.L. 101-239, §10208(d)(2)(A)(v), struck out "paragraph (2) of section 209(h)" and substituted "subparagraph (B) of section 209(a)(7)", effective December 19, 1989.

[427] P.L. 101-508, §11332(c)(1), struck out "and".

[428] P.L. 101-508, §11332(c)(2). struck out a period and substituted ", and".

[429] P.L. 101-508, §11332(c)(3), added subparagraph (F), applicable to service performed after July 1, 1991. Alignment as in original.

member of such a system (but only if the agreement is not already applicable to such system pursuant to subsection (d)(3)), whichever may be desired by the State.

(8) Notwithstanding any other provision of this section, the agreement with any State entered into under this section may at the option of the State be modified on or after January 1, 1968, to exclude service performed by election officials or election workers if the remuneration paid in a calendar year for such service is less than $100. Any modification of an agreement pursuant to this paragraph shall be effective with respect to services performed after an effective date, specified in such modification, which shall not be earlier than the last day of the calendar quarter[430] in which the modification is mailed or delivered by other means to the Secretary.

Positions Covered By Retirement Systems

(d)(1)No agreement with any State may be made applicable (either in the original agreement or by any modification thereof) to any service performed by employees as members of any coverage group in positions covered by a retirement system either (A) on the date such agreement is made applicable to such coverage group, or (B) on the date of enactment of the succeeding paragraph of this subsection[431] (except in the case of positions which are, by reason of action by such State or political subdivision thereof, as may be appropriate, taken prior to the date of enactment of such succeeding paragraph[432], no longer covered by a retirement system on the date referred to in clause (A), and except in the case of positions excluded by paragraph (5)(A)). The preceding sentence shall not be applicable to any service performed by an employee as a member of any coverage group in a position (other than a position excluded by paragraph (5)(A)) covered by a retirement system on the date an agreement is made applicable to such coverage group if, on such date (or, if later, the date on which such individual first occupies such position), such individual is ineligible to be a member of such system.

(2)It is hereby declared to be the policy of the Congress in enacting the succeeding paragraphs of this subsection that the protection afforded employees in positions covered by a retirement system on the date an agreement under this section is made applicable to service performed in such positions, or receiving periodic benefits under such retirement system at such time, will not be impaired as a result of making the agreement so applicable or as a result of legislative enactment in anticipation thereof.

(3)Notwithstanding paragraph (1), an agreement with a State may be made applicable (either in the original agreement or by any modification thereof) to service performed by employees in positions covered by a retirement system (including positions specified in paragraph (4) but not including positions excluded by or pursuant to paragraph (5)), if the governor of the State, or an official of the State designated by him for the purpose, certifies to the Secretary that the following conditions have been met:

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[430] As in original. This may be inconsistent with calendar "year" used in previous sentence.

[431] September 1, 1954 [P.L. 83- 761; 68 Stat. 1056].

[432] September 1, 1954 [P.L. 83-761; 68 Stat. 1056].

(A) A referendum by secret written ballot was held on the question of whether service in positions covered by such retirement system should be excluded from or included under an agreement under this section;

(B) An opportunity to vote in such referendum was given (and was limited) to eligible employees;

(C) Not less than ninety days' notice of such referendum was given to all such employees;

(D) Such referendum was conducted under the supervision of the governor or an agency or individual designated by him; and

(E) A majority of the eligible employees voted in favor of including service in such positions under an agreement under this section.

An employee shall be deemed an "eligible employee" for purposes of any referendum with respect to any retirement system if, at the time such referendum was held, he was in a position covered by such retirement system and was a member of such system, and if he was in such a position at the time notice of such referendum was given as required by clause (C) of the preceding sentence; except that he shall not be deemed an "eligible employee" if, at the time the referendum was held, he was in a position to which the State agreement already applied, or if he was in a position excluded by or pursuant to paragraph (5). No referendum with respect to a retirement system shall be valid for purposes of this paragraph unless held within the two-year period which ends on the date of execution of the agreement or modification which extends the insurance system established by this title to such retirement system, nor shall any referendum with respect to a retirement system be valid for purposes of this paragraph if held less than one year after the last previous referendum held with respect to such retirement system.

(4) For the purposes of subsection (c) of this section, the following employees shall be deemed to be a separate coverage group—

(A) all employees in positions which were covered by the same retirement system on the date the agreement was made applicable to such system (other than employees to whose services the agreement already applied on such date);

(B) all employees in positions which became covered by such system at any time after such date; and

(C) all employees in positions which were covered by such system at any time before such date and to whose services the insurance system established by this title has not been extended before such date because the positions were covered by such retirement system (including employees to whose services the agreement was not applicable on such date because such services were excluded pursuant to subsection (c)(3)(B)).

(5)(A) Nothing in paragraph (3) of this subsection shall authorize the extension of the insurance system established by this title to service in any policeman's or fireman's position.

(B) At the request of the State, any class or classes of positions covered by a retirement system which may be excluded from the agreement pursuant to paragraph (3) or (5) of subsection (c), and to which the agreement does not already apply, may be excluded from the agreement at the time it is made applicable to such retirement system; except that, notwithstanding the provisions of paragraph

(3)(B) of such subsection, such exclusion may not include any services to which such paragraph (3)(B) is applicable. In the case of any such exclusion, each such class so excluded shall, for purposes of this subsection, constitute a separate retirement system in case of any modification of the agreement thereafter agreed to.

(6)(A) If a retirement system covers positions of employees of the State and positions of employees of one or more political subdivisions of the State, or covers positions of employees of two or more political subdivisions of the State, then, for purposes of the preceding paragraphs of this subsection, there shall, if the State so desires, be deemed to be a separate retirement system with respect to any one or more of the political subdivisions concerned and, where the retirement system covers positions of employees of the State, a separate retirement system with respect to the State or with respect to the State and any one or more of the political subdivisions concerned. Where a retirement system covering positions of employees of a State and positions of employees of one or more political subdivisions of the State, or covering positions of employees of two or more political subdivisions of the State, is not divided into separate retirement systems pursuant to the preceding sentence or pursuant to subparagraph (C), then the State may, for purposes of subsection (e) only, deem the system to be a separate retirement system with respect to any one or more of the political subdivisions concerned and, where the retirement system covers positions of employees of the State, a separate retirement system with respect to the State or with respect to the State and any one or more of the political subdivisions concerned.

(B) If a retirement system covers positions of employees of one or more institutions of higher learning, then, for purposes of such preceding paragraphs there shall, if the State so desires, be deemed to be a separate retirement system for the employees of each such institution of higher learning. For the purposes of this subparagraph, the term "institutions of higher learning" includes junior colleges and teachers colleges. If a retirement system covers positions of employees of a hospital which is an integral part of a political subdivision, then, for purposes of the preceding paragraphs there shall, if the State so desires, be deemed to be a separate retirement system for the employees of such hospital.

(C) For the purposes of this subsection, any retirement system established by the State of Alaska, California, Connecticut, Florida, Georgia, Illinois, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Washington, Wisconsin, or Hawaii, or any political subdivision of any such State, which, on, before, or after the date of enactment of this subparagraph[433], is divided into two divisions or parts, one of which is composed of positions of members of such system who desire coverage under an agreement under this section and the other of which is composed of positions of members of such system who do not desire such coverage, shall, if the State so desires and if it is provided that there shall be included in such division or part composed of members desiring such coverage the positions of individuals who become members of such system after such coverage is extended, be deemed to be a separate retirement system with respect to each such division or part. If, in the case of a separate retirement system which is deemed to exist by reason of subparagraph (A) and which has been divided into two divisions or parts pursuant to the first sentence of this subparagraph, individuals become members of such system by reason of action taken by a political subdivision after coverage under an agreement under this section has been extended to the division or part thereof composed of positions of individuals who desire such coverage, the positions of such individuals who become members of such retirement system by reason of the action so taken shall be included in the division or part of such system composed of positions of members who do not desire such coverage if (i) such individuals, on the day before becoming such members, were in the division or part of another separate retirement system (deemed to exist by reason of subparagraph (A)) composed of positions of members of such system who do not desire coverage under an agreement under this section, and (ii) all of the positions in the separate retirement system of which such individuals so become members and all of the positions in the separate retirement system referred to in clause (i) would have been covered by a single retirement system if the State had not taken action to provide for separate retirement systems under this paragraph.

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[433] P.L. 84-880, §104(e), enacted this sentence August 1, 1956.
P.L. 85-840, §315(a)(1), enacted this subparagraph August 28, 1958.

(D)(i) The position of any individual which is covered by any retirement system to which subparagraph (C) is applicable shall, if such individual is ineligible to become a member of such system on August 1, 1956, or, if later, the day he first occupies such position, be deemed to be covered by the separate retirement system consisting of the positions of members of the division or part who do not desire coverage under the insurance system established under this title.

(ii) Notwithstanding clause (i), the State may, pursuant to subsection (c)(4)(B) and subject to the conditions of continuation or termination of coverage provided for in subsection (c)(7), modify its agreement under this section to include services performed by all individuals described in clause (i) other than those individuals to whose services the agreement already applies. Such individuals shall be deemed (on and after the effective date of the modification) to be in positions covered by the separate retirement system consisting of the positions of members of the division or part who desire coverage under the insurance system established under this title.

(E) An individual who is in a position covered by a retirement system to which subparagraph (C) is applicable and who is not a member of such system but is eligible to become a member thereof shall, for purposes of this subsection (other than paragraph (8)), be regarded as a member of such system; except that, in the case of any retirement system a division or part of which is covered under the agreement (either in the original agreement or by a modification thereof), which coverage is agreed to prior to 1960, the preceding provisions of this subparagraph shall apply only if the State so requests and any such individual referred to in such preceding provisions shall, if the State so requests, be treated, after division of the retirement system pursuant to such subparagraph (C), the same as individuals in positions referred to in subparagraph (F).

(F) In the case of any retirement system divided pursuant to subparagraph (C), the position of any member of the division or part composed of positions of members who do not desire coverage may be transferred to the separate retirement system composed of positions of members who desire such coverage if it is so provided in a modification of such agreement which is mailed, or delivered by other means, to the Secretary prior to 1970 or, if later, the expiration of two years after the date on which such agreement, or the modification thereof making the agreement applicable to such separate retirement system, as the case may be, is agreed to, but only if, prior to such modification or such later modification, as the case may be, the individual occupying such position files with the State a written request for such transfer. Notwithstanding subsection (e)(1), any such modification or later modification, providing for the transfer of additional positions within a retirement system previously divided pursuant to subparagraph (C) to the separate retirement system composed of positions of members who desire coverage, shall be effective with respect to services performed after the same effective date as that which was specified in the case of such previous division.

(G) For the purposes of this subsection, in the case of any retirement system of the State of Florida, Georgia, Minnesota, North Dakota, Pennsylvania, Washington, or Hawaii which covers positions of employees of such State who are compensated in whole or in part from grants made to such State under title III, there shall be deemed to be, if such State so desires, a separate retirement system with respect to any of the following:

(i) the positions of such employees;

(ii) the positions of all employees of such State covered by such retirement system who are employed in the department of such State in which the employees referred to in clause (i) are employed; or

(iii) employees of such State covered by such retirement system who are employed in such department of such State in positions other than those referred to in clause (i).

(7) The certification by the governor (or an official of the State designated by him for the purpose) required under paragraph (3) shall be deemed to have been made, in the case of a division or part (created under subparagraph (C) of paragraph (6) or the corresponding provision of prior law) consisting of the positions of members of a retirement system who desire coverage under the agreement under this section, if the governor (or the official so designated) certifies to the Secretary that—

(A) an opportunity to vote by written ballot on the question of whether they wish to be covered under an agreement under this section was given to all individuals who were members of such system at the time the vote was held;

(B) not less than ninety days' notice of such vote was given to all individuals who were members of such system on the date the notice was issued;

(C) the vote was conducted under the supervision of the governor or an agency or individual designated by him; and

(D) such system was divided into two parts or divisions in accordance with the provisions of subparagraphs (C) and (D) of paragraph (6) or the corresponding provision of prior law.

For purposes of this paragraph, an individual in a position to which the State agreement already applied or in a position excluded by or pursuant to paragraph (5) shall not be considered a member of the retirement system.

(8)(A) Notwithstanding paragraph (1), if under the provisions of this subsection an agreement is, after December 31, 1958, made applicable to service performed in positions covered by a retirement system, service performed by an individual in a position covered by such a system may not be excluded from the agreement because such position is also covered under another retirement system.

(B) Subparagraph (A) shall not apply to service performed by an individual in a position covered under a retirement system if such individual, on the day the agreement is made applicable to service performed in positions covered by such retirement system, is not a member of such system and is a member of another system.

(C) If an agreement is made applicable, prior to 1959, to service in positions covered by any retirement system, the preceding provisions of this paragraph shall be applicable in the case of such system if the agreement is modified to so provide.

(D) Except in the case of agreements with the States named in subsection (l) and agreements with interstate instrumentalities, nothing in this paragraph shall authorize the application of an agreement to service in any policeman's or fireman's position.

Effective Date of Agreement

(e)(1) Any agreement or modification of an agreement under this section shall be effective with respect to services performed after an effective date specified in such agreement or modification; except that such date may not be earlier than the last day of the sixth calendar year preceding the year in which such agreement or modification, as the case may be, is mailed or delivered by other means to the Secretary.

(2) In the case of service performed by members of any coverage group—

(A) to which an agreement under this section is made applicable, and

(B) with respect to which the agreement, or modification thereof making the agreement so applicable, specifies an effective date earlier than the date of execution of such agreement and such modification, respectively,

the agreement shall, if so requested by the State, be applicable to such services (to the extent the agreement was not already applicable) performed before such date of execution and after such effective date by any individual as a member of such coverage group if he is such a member on a date, specified by the State, which is earlier than such date of execution, except that in no case may the date so specified be earlier than the date such agreement or such modification, as the case may be, is mailed, or delivered by other means, to the Secretary.

(3) Notwithstanding the provisions of paragraph (2) of this subsection, in the case of services performed by individuals as members of any coverage group to which an agreement under this section is made applicable, and with respect to which there were timely paid in

good faith to the Secretary of the Treasury amounts equivalent to the sum of the taxes which would have been imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954[434] had such services constituted employment for purposes of chapter 21 of such Code[435] at the time they were performed, and with respect to which refunds were not obtained, such individuals may, if so requested by the State, be deemed to be members of such coverage group on the date designated pursuant to paragraph (2).

Duration of Agreement

(f) No agreement under this section may be terminated, either in its entirety or with respect to any coverage group, on or after the date of the enactment of the Social Security Amendments of 1983[436].

Instrumentalities of Two or More States

(g)(1) The Secretary may, at the request of any instrumentality of two or more States, enter into an agreement with such instrumentality for the purpose of extending the insurance system established by this title to services performed by individuals as employees of such instrumentality. Such agreement, to the extent practicable, shall be governed by the provisions of this section applicable in the case of an agreement with a State.

(2) In the case of any instrumentality of two or more States, if—

(A) employees of such instrumentality are in positions covered by a retirement system of such instrumentality or of any of such States or any of the political subdivisions thereof, and

(B) such retirement system is (on, before, or after the date of enactment of this paragraph[437]) divided into two divisions or parts, one of which is composed of positions of members of such system who are employees of such instrumentality and who desire coverage under an agreement under this section and the other of which is composed of positions of members of such system who are employees of such instrumentality and who do not desire such coverage, and

(C) it is provided that there shall be included in such division or part composed of the positions of members desiring such coverage the positions of employees of such instrumentality who become members of such system after such coverage is extended,

then such retirement system shall, if such instrumentality so desires, be deemed to be a separate retirement system with respect to each such division or part. An individual who is in a position covered by a retirement system divided pursuant to the preceding sentence and who is not a member of such system but is eligible to become a member thereof shall, for purposes of this subsection, be regarded as a member of such system. Coverage under the agreement of any such individual shall be provided under the same conditions, to the extent practicable, as are applicable in the case of the States to which the provisions of subsection (d)(6)(C) apply. The position of any employee of any such instrumentality which is covered by any retirement system to which the first sentence of this paragraph is applicable shall, if such individual is ineligible to become a member of such system on the date of enactment of this paragraph[438] or, if later, the day he first occupies such position, be deemed to be covered by the separate retirement system consisting of the positions of members of the division or part who do not desire coverage under the insurance system established under this title. Services in positions covered by a separate retirement system created pursuant to this subsection (and consisting of the positions of members who desire coverage under an agreement under this section) shall be covered under such agreement on compliance, to the extent practicable, with the same conditions as are applicable to coverage under an agreement under this section of services in positions covered by a separate retirement system created pursuant to subparagraph (C) of subsection (d)(6) or the corresponding provision of prior law (and consisting of the positions of members who desire coverage under such agreement).

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[434] See P.L. 83-591, §3101; (this volume).

[435] See P.L. 83-591, chapter 21; (this volume).

[436] April 20, 1983 [P.L. 98-21; 97 Stat. 65].

[437] August 30, 1957 [P.L. 85-226; 71 Stat. 511].

(3) Any agreement with any instrumentality of two or more States entered into pursuant to this Act may, notwithstanding the provisions of subsection (d)(5)(A) and the references thereto in subsections (d)(1) and (d)(3), apply to service performed by employees of such instrumentality in any policeman's or fireman's position covered by a retirement system, but only upon compliance, to the extent practicable, with the requirements of subsection (d)(3). For the purpose of the preceding sentence, a retirement system which covers positions of policemen or firemen or both, and other positions shall, if the instrumentality concerned so desires, be deemed to be a separate retirement system with respect to the positions of such policemen or firemen, or both, as the case may be.

Delegation of Functions

(h) The Secretary is authorized, pursuant to agreement with the head of any Federal agency, to delegate any of his functions under this section to any officer or employee of such agency and otherwise to utilize the services and facilities of such agency in carrying out such functions, and payment therefor shall be in advance or by way of reimbursement, as may be provided in such agreement.

Wisconsin Retirement Fund

(i)(1) Notwithstanding paragraph (1) of subsection (d), the agreement with the State of Wisconsin may, subject to the provisions of this subsection, be modified so as to apply to service performed by employees in positions covered by the Wisconsin retirement fund or any successor system.

(2) All employees in positions covered by the Wisconsin retirement fund at any time on or after January 1, 1951, shall, for the purposes of subsection (c) only, be deemed to be a separate coverage group; except that there shall be excluded from such separate coverage group all employees in positions to which the agreement applies without regard to this subsection.

(3) The modification pursuant to this subsection shall exclude (in the case of employees in the coverage group established by para-

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[438] August 30, 1957 [P.L. 85-226; 71 Stat. 511].

graph (2) of this subsection) service performed by any individual during any period before he is included under the Wisconsin retirement fund.

(4) The modification pursuant to this subsection shall, if the State of Wisconsin requests it, exclude (in the case of employees in the coverage group established by paragraph (2) of this subsection) all service performed in policemen's positions, all service performed in firemen's positions, or both.

Certain Positions No Longer Covered By Retirement Systems

(j) Notwithstanding subsection (d), an agreement with any State entered into under this section prior to the date of the enactment of this subsection[439] may, prior to January 1, 1958, be modified pursuant to subsection (c)(4) so as to apply to services performed by employees, as members of any coverage group to which such agreement already applies (and to which such agreement applied on such date of enactment), in positions (1) to which such agreement does not already apply, (2) which were covered by a retirement system on the date such agreement was made applicable to such coverage group, and (3) which, by reason of action by such State or political subdivision thereof, as may be appropriate, taken prior to the date of the enactment of this subsection, are no longer covered by a retirement system on the date such agreement is made applicable to such services.

Certain Employees of the State of Utah

(k) Notwithstanding the provisions of subsection (d), the agreement with the State of Utah entered into pursuant to this section may be modified pursuant to subsection (c)(4) so as to apply to services performed for any of the following, the employees performing services for each of which shall constitute a separate coverage group: Weber Junior College, Carbon Junior College, Dixie Junior College, Central Utah Vocational School, Salt Lake Area Vocational School, Center for the Adult Blind, Union High School (Roosevelt, Utah), Utah High School Activities Association, State Industrial School, State Training School, State Board of Education, and Utah School Employees Retirement Board. Any modification agreed to prior to January 1, 1955, may be made effective with respect to services performed by employees as members of any of such coverage groups after an effective date specified therein, except that in no case may any such date be earlier than December 31, 1950. Coverage provided for in this subsection shall not be affected by a subsequent change in the name of a group.

Policemen and Firemen in Certain States

(l)(1) Any agreement with the State of Alabama, California, Florida, Georgia, Hawaii, Idaho, Kansas, Maine, Maryland, Mississippi, Montana, New York, North Carolina, North Dakota, Oregon, Puerto Rico, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, or Washington entered into pursuant to this section prior to the date of enactment of this subsection[440] may, notwithstanding the provisions of subsection (d)(5)(A) and the references thereto in subsections (d)(1) and (d)(3), be modified pursuant to subsection (c)(4) to apply to service performed by employees of such State or any political subdivision thereof in any policeman's or fireman's position covered by a retirement system in effect on or after the date of the enactment of this subsection, but only upon compliance with the requirements of subsection (d)(3). For the purposes of the preceding sentence, a retirement system which covers positions of policemen or firemen, or both, and other positions shall, if the State concerned so desires, be deemed to be a separate retirement system with respect to the positions of such policemen or firemen, or both, as the case may be.

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[439] September 1, 1954 [P.L. 83-761; 68 Stat. 1058].

[440] August 1, 1956 [P.L. 84-880; 70 Stat. 826].

(2) A State, not otherwise listed by name in paragraph (1), shall be deemed to be a State listed in such paragraph for the purpose of extending coverage under this title to service in firemen's positions covered by a retirement system, if the governor of the State, or an official of the State designated by him for the purpose, certifies to the Secretary that the overall benefit protection of the employees in such positions would be improved by reason of the extension of such coverage to such employees. Notwithstanding the provisions of the second sentence of such paragraph (1), such firemen's positions shall be deemed a separate retirement system and no other positions shall be included in such system.

Positions Compensated Solely on a Fee Basis

(m)(1) Notwithstanding any other provision in this section, an agreement entered into under this section may be made applicable to service performed after 1967 in any class or classes of positions compensated solely on a fee basis to which such agreement did not apply prior to 1968 only if the State specifically requests that its agreement be made applicable to such service in such class or classes of positions.

(2) Notwithstanding any other provision in this section, an agreement entered into under this section may be modified, at the option of the State, at any time after 1967, so as to exclude services performed in any class or classes of positions compensation for which is solely on a fee basis.

(3) Any modification made under this subsection shall be effective with respect to services performed after the last day of the calendar year in which the modification is mailed or delivered by other means to the Secretary.

(4) If any class or classes of positions have been excluded from coverage under the State agreement by a modification agreed to under this subsection, the Secretary and the State may not thereafter modify such agreement so as to again make the agreement applicable with respect to such class or classes of positions.

(n)(1) The Secretary shall, at the request of any State, enter into or modify an agreement with such State under this section for the purpose of extending the provisions of title XVIII, and sections 226 and 226A, to services performed by employees of such State or any political subdivision thereof who are described in paragraph (2).

(2) This subsection shall apply only with respect to employees —

(A) whose services are not treated as employment as that term applies under section 210(p) by reason of paragraph (3) of such section; and

(B) who are not otherwise covered under the State's agreement under this section.

(3) For purposes of sections 226 and 226A of this Act, services covered under an agreement pursuant to this subsection shall be treated as "medicare qualified government employment".

(4) Except as otherwise provided in this subsection, the provisions of this section shall apply with respect to services covered under the agreement pursuant to this subsection.

[SEC. 219. Repealed.[441]]

DISABILITY PROVISIONS INAPPLICABLE IF BENEFIT RIGHTS IMPAIRED

SEC. 220. [42 U.S.C. 420] None of the provisions of this title relating to periods of disability shall apply in any case in which their application would result in the denial of monthly benefits or a lump-sum death payment which would otherwise be payable under this title; nor shall they apply in the case of any monthly benefit or lump-sum death payment under this title if such benefit or payment would be greater without their application.

DISABILITY DETERMINATIONS

SEC. 221. [42 U.S.C. 421] (a) (1) In the case of any individual, the determination of whether or not he is under a disability (as defined in section 216(i) or 223(d)) and of the day such disability began, and the determination of the day on which such disability ceases, shall be made by a State agency, notwithstanding any other provision of law, in any State that notifies the Secretary in writing that it wishes to make such disability determinations commencing with such month as the Secretary and the State agree upon, but only if (A) the Secretary has not found, under subsection (b)(1), that the State agency has substantially failed to make disability determinations in accordance with the applicable provisions of this section or rules issued thereunder, and (B) the State has not notified the Secretary, under subsection (b)(2), that it does not wish to make such determinations. If the Secretary once makes the finding described in clause (A) of the preceding sentence, or the State gives the notice referred to in clause (B) of such sentence, the Secretary may thereafter determine whether (and, if so, beginning with which month and under what conditions) the State may again make disability determinations under this paragraph.

(2) The disability determinations described in paragraph (1) made by a State agency shall be made in accordance with the pertinent provisions of this title and the standards and criteria contained in regulations or other written guidelines of the Secretary pertaining to matters such as disability determinations, the class or classes of individuals with respect to which a State may make disability determinations (if it does not wish to do so with respect to all individuals in the State), and the conditions under which it may choose not to make all such determinations. In addition, the Secre-

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[441] P.L. 86-778, §103(j)(1); 74 Stat. 937.

tary shall promulgate regulations specifying, in such detail as he deems appropriate, performance standards and administrative requirements and procedures to be followed in performing the disability determination function in order to assure effective and uniform administration of the disability insurance program throughout the United States. The regulations may, for example, specify matters such as—

(A) the administrative structure and the relationship between various units of the State agency responsible for disability determinations,

(B) the physical location of and relationship among agency staff units, and other individuals or organizations performing tasks for the State agency, and standards for the availability to applicants and beneficiaries of facilities for making disability determinations,

(C) State agency performance criteria, including the rate of accuracy of decisions, the time periods within which determinations must be made, the procedures for and the scope of review by the Secretary, and, as he finds appropriate, by the State, of its performance in individual cases and in classes of cases, and rules governing access of appropriate Federal officials to State offices and to State records relating to its administration of the disability determination function,

(D) fiscal control procedures that the State agency may be required to adopt, and

(E) the submission of reports and other data, in such form and at such time as the Secretary may require, concerning the State agency's activities relating to the disability determination.

Nothing in this section shall be construed to authorize the Secretary to take any action except pursuant to law or to regulations promulgated pursuant to law.

(b)(1) If the Secretary finds, after notice and opportunity for a hearing, that a State agency is substantially failing to make disability determinations in a manner consistent with his regulations and other written guidelines, the Secretary shall, not earlier than 180 days following his finding, and after he has complied with the requirements of paragraph (3), make the disability determinations referred to in subsection (a)(1).

(2) If a State, having notified the Secretary of its intent to make disability determinations under subsection (a)(1), no longer wishes to make such determinations, it shall notify the Secretary in writing of that fact, and, if an agency of the State is making disability determinations at the time such notice is given, it shall continue to do so for not less than 180 days, or (if later) until the Secretary has complied with the requirements of paragraph (3). Thereafter, the Secretary shall make the disability determinations referred to in subsection (a)(1).

(3)(A) The Secretary shall develop and initiate all appropriate procedures to implement a plan with respect to any partial or complete assumption by the Secretary of the disability determination function from a State agency, as provided in this section, under which employees of the affected State agency who are capable of performing duties in the disability determination process for the Secretary shall, notwithstanding any other provision of law, have a preference over any other individual in filling an appropriate employment position with the Secretary (subject to any system established by the Secretary for determining hiring priority among such employees of the State agency) unless any such employee is the administrator, the deputy administrator, or assistant administrator (or his equivalent) of the State agency, in which case the Secretary may accord such priority to such employee.

(B) The Secretary shall not make such assumption of the disability determination function until such time as the Secretary of Labor determines that, with respect to employees of such State agency who will be displaced from their employment on account of such assumption by the Secretary and who will not be hired by the Secretary to perform duties in the disability determination process, the State has made fair and equitable arrangements to protect the interests of employees so displaced. Such protective arrangements shall include only those provisions which are provided under all applicable Federal, State and local statutes including, but not limited to, (i) the preservation of rights, privileges, and benefits (including continuation of pension rights and benefits) under existing collective-bargaining agreements; (ii) the continuation of collective-bargaining rights; (iii) the assignment of affected employees to other jobs or to retraining programs; (iv) the protection of individual employees against a worsening of their positions with respect to their employment; (v) the protection of health benefits and other fringe benefits; and (vi) the provision of severance pay, as may be necessary.

(c)(1) The Secretary may on his own motion or as required under paragraphs (2) and (3) review a determination, made by a State agency under this section, that an individual is or is not under a disability (as defined in section 216(i) or 223(d)) and, as a result of such review, may modify such agency's determination and determine that such individual either is or is not under a disability (as so defined) or that such individual's disability began on a day earlier or later than that determined by such agency, or that such disability ceased on a day earlier or later than that determined by such agency. A review by the Secretary on his own motion of a State agency determination under this paragraph may be made before or after any action is taken to implement such determination.

(2) The Secretary (in accordance with paragraph (3)) shall review determinations, made by State agencies pursuant to this section, that individuals are under disabilities (as defined in section 216(i) or 223(d)). Any review by the Secretary of a State agency determination under this paragraph shall be made before any action is taken to implement such determination.

(3)(A) In carrying out the provisions of paragraph (2) with respect to the review of determinations made by State agencies pursuant to this section that individuals are under disabilities (as defined in section 216(i) or 223(d)), the Secretary shall review—

(i) at least 50 percent of all such determinations made by State agencies on applications for benefits under this title, and

(ii) other determinations made by State agencies pursuant to this section to the extent necessary to assure a high level of accuracy in such other determinations.

(B) In conducting reviews pursuant to subparagraph (A), the Secretary shall, to the extent feasible, select for review those determinations which the Secretary identifies as being the most likely to be incorrect.

(C) Not later than April 1, 1992, and annually thereafter, the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a written report setting forth the number of reviews conducted under subparagraph (A)(ii) during the preceding fiscal year and the findings of the Secretary based on such reviews of the accuracy of the determinations made by State agencies pursuant to this section.[442]

(d) Any individual dissatisfied with any determination under subsection (a), (b), (c), or (g) shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) with respect to decisions of the Secretary, and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(e) Each State which is making disability determinations under subsection (a)(1) shall be entitled to receive from the Trust Funds, in advance or by way of reimbursement, as determined by the Secretary, the cost to the State of making disability determinations under subsection (a)(1). The Secretary shall from time to time certify such amount as is necessary for this purpose to the Managing Trustee, reduced or increased, as the case may be, by any sum (for which adjustment hereunder has not previously been made) by which the amount certified for any prior period was greater or less than the amount which should have been paid to the State under this subsection for such period; and the Managing Trustee, prior to audit or settlement by the General Accounting Office, shall make payment from the Trust Funds at the time or times fixed by the Secretary, in accordance with such certification. Appropriate adjustments between the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund with respect to the payments made under this subsection shall be made in accordance with paragraph (1) of subsection (g) of section 201 (but taking into account any refunds under subsection (f) of this section) to insure that the Federal Disability Insurance Trust Fund is charged with all expenses incurred which are attributable to the administration of section 223 and the Federal Old-Age and Survivors Insurance Trust Fund is charged with all other expenses.

(f) All money paid to a State under this section shall be used solely for the purposes for which it is paid; and any money so paid which is not used for such purposes shall be returned to the Treasury of the United States for deposit in the Trust Funds.

(g) In the case of individuals in a State which does not undertake to perform disability determinations under subsection (a)(1), or which has been found by the Secretary to have substantially failed to make disability determinations in a manner consistent with his regulations and guidelines, in the case of individuals outside the United States, and in the case of any class or classes of individuals for whom no State undertakes to make disability determinations, the determinations referred to in subsection (a) shall be made by the Secretary in accordance with regulations prescribed by him.

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[442] P.L. 101-508, §5128(a), amended paragraph (3) in its entirety, applicable to determinations made by State agencies in fiscal years after fiscal year 1990. [For paragraph (3) as it formerly read, see Vol. III, P.L. 101-508.]

(h) An initial determination under subsection (a), (c), (g), or (i) that an individual is not under a disability, in any case where there is evidence which indicates the existence of a mental impairment, shall be made only if the Secretary has made every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment.

(i)(1) In any case where an individual is or has been determined to be under a disability, the case shall be reviewed by the applicable State agency or the Secretary (as may be appropriate), for purposes of continuing eligibility, at least once every 3 years, subject to paragraph (2); except that where a finding has been made that such disability is permanent, such reviews shall be made at such times as the Secretary determines to be appropriate. Reviews of cases under the preceding sentence shall be in addition to, and shall not be considered as a substitute for, any other reviews which are required or provided for under or in the administration of this title.

(2) The requirement of paragraph (1) that cases be reviewed at least every 3 years shall not apply to the extent that the Secretary determines, on a State-by-State basis, that such requirement should be waived to insure that only the appropriate number of such cases are reviewed. The Secretary shall determine the appropriate number of cases to be reviewed in each State after consultation with the State agency performing such reviews, based upon the backlog of pending reviews, the projected number of new applications for disability insurance benefits, and the current and projected staffing levels of the State agency, but the Secretary shall provide for a waiver of such requirement only in the case of a State which makes a good faith effort to meet proper staffing requirements for the State agency and to process case reviews in a timely fashion. The Secretary shall report annually to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives with respect to the determinations made by the Secretary under the preceding sentence.

(3) The Secretary shall report annually to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives with respect to the number of reviews of continuing disability carried out under paragraph (1), the number of such reviews which result in an initial termination of benefits, the number of requests for reconsideration of such initial termination or for a hearing with respect to such termination under subsection (d), or both, and the number of such initial terminations which are overturned as the result of a reconsideration or hearing.

(4) In any case in which the Secretary initiates a review under this subsection of the case of an individual who has been determined to be under a disability, the Secretary shall notify such individual of the nature of the review to be carried out, the possibility that such review could result in the termination of benefits, and the right of the individual to provide medical evidence with respect to such review.

(j) The Secretary shall prescribe regulations which set forth, in detail—

(1) the standards to be utilized by State disability determination services and Federal personnel in determining when a

consultative examination should be obtained in connection with disability determinations;

(2) standards for the type of referral to be made; and

(3) procedures by which the Secretary will monitor both the referral processes used and the product of professionals to whom cases are referred.

Nothing in this subsection shall be construed to preclude the issuance, in accordance with section 553(b)(A) of title 5, United States Code, of interpretive rules, general statements of policy, and rules of agency organization relating to consultative examinations if such rules and statements are consistent with such regulations.

(k)(1) The Secretary shall establish by regulation uniform standards which shall be applied at all levels of determination, review, and adjudication in determining whether individuals are under disabilities as defined in section 216(i) or 223(d).

(2) Regulations promulgated under paragraph (1) shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code.

(l)(1) In any case where an individual who is applying for or receiving benefits under this title on the basis of disability by reason of blindness is entitled to receive notice from the Secretary of any decision or determination made or other action taken or proposed to be taken with respect to his or her rights under this title, such individual shall at his or her election be entitled either (A) to receive a supplementary notice of such decision, determination, or action, by telephone, within 5 working days after the initial notice is mailed, (B) to receive the initial notice in the form of a certified letter, or (C) to receive notification by some alternative procedure established by the Secretary and agreed to by the individual.

(2) The election under paragraph (1) may be made at any time, but an opportunity to make such an election shall in any event be given, to every individual who is an applicant for benefits under this title on the basis of disability by reason of blindness, at the time of his or her application. Such an election, once made by an individual, shall apply with respect to all notices of decisions, determinations, and actions which such individual may thereafter be entitled to receive under this title until such time as it is revoked or changed.[443]

REHABILITATION SERVICES

Referral for Rehabilitation Services

SEC. 222. [42 U.S.C. 422] (a) It is hereby declared to be the policy of the Congress that disabled individuals applying for a determination of disability, and disabled individuals who are entitled to child's insurance benefits, widow's insurance benefits, or widower's insurance benefits, shall be promptly referred to the State agency or agencies administering or supervising the administration of the State plan approved under title I of the Rehabilitation Act of 1973[444] for necessary vocational rehabilitation services, to the end that the maximum number of such individuals may be rehabilitated into productive activity.

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[443] P.L. 101-239, §10306(a)(1), added subsection (l), applicable with respect to notices issued on or after July 1, 1990.

See Vol. II, P.L. 101-239, §10306(a)(2), with respect to application to current recipients; and §10306(b), with respect to a report regarding notices in languages other than English.

[444] P.L. 93-112.

Deductions on Account of Refusal To Accept Rehabilitation Services

(b)(1) Deductions, in such amounts and at such time or times as the Secretary shall determine, shall be made from any payment or payments under this title to which an individual is entitled, until the total of such deductions equals such individual's benefit or benefits under sections 202 and 223 for any month in which such individual, if a child who has attained the age of eighteen and is entitled to child's insurance benefits, a widow, widower, surviving divorced wife, or surviving divorced husband who has not attained age 60, or an individual entitled to disability insurance benefits, refuses without good cause to accept rehabilitation services available to him under a State plan approved under title I of the Rehabilitation Act of 1973. Any individual who is a member or adherent of any recognized church or religious sect which teaches its members or adherents to rely solely, in the treatment and cure of any physical or mental impairment, upon prayer or spiritual means through the application and use of the tenets or teachings of such church or sect, and who, solely because of his adherence to the teachings or tenets of such church, or sect, refuses to accept rehabilitation services available to him under a State plan approved under title I of the Rehabilitation Act of 1973, shall, for the purposes of the first sentence of this subsection, be deemed to have done so with good cause.

(2) Deductions shall be made from any child's insurance benefit to which a child who has attained the age of eighteen is entitled or from any mother's or father's insurance benefit to which a person is entitled, until the total of such deductions equals such child's insurance benefit or benefits or such mother's or father's insurance benefit or benefits under section 202 for any month in which such child or person entitled to mother's or father's insurance benefits is married to an individual who is entitled to disability insurance benefits and in which such individual refuses to accept rehabilitation services and a deduction, on account of such refusal, is imposed under paragraph (1). If both this paragraph and paragraph (3) are applicable to a child's insurance benefit for any month, only an amount equal to such benefit shall be deducted.

(3) Deductions shall be made from any wife's, husband's, or child's insurance benefit, based on the wages and self-employment income of an individual entitled to disability insurance benefits, to which a wife, divorced wife, husband, divorced husband, or child is entitled, until the total of such deductions equals such wife's, husband's, or child's insurance benefit or benefits under section 202 for any month in which the individual, on the basis of whose wages and self-employment income such benefit was payable, refuses to accept rehabilitation services and deductions, on account of such refusal, are imposed under paragraph (1).

(4) The provisions of paragraph (1) shall not apply to any child entitled to benefits under section 202(d), if he has attained the age of 18 but has not attained the age of 22, for any month during which he is a full-time elementary or secondary school student (as defined and determined under section 202(d)).

Period of Trial Work

(c)(1) The term "period of trial work", with respect to an individual entitled to benefits under section 223, 202(d), 202(e), or 202(f), means a period of months beginning and ending as provided in paragraphs (3) and (4).

(2) For purposes of sections 216(i) and 223, any services rendered by an individual during a period of trial work shall be deemed not to have been rendered by such individual in determining whether his disability has ceased in a month during such period. For purposes of this subsection the term "services" means activity which is performed for remuneration or gain or is determined by the Secretary to be of a type normally performed for remuneration or gain.

(3) A period of trial work for any individual shall begin with the month in which he becomes entitled to disability insurance benefits, or, in the case of an individual entitled to benefits under section 202(d) who has attained the age of eighteen, with the month in which he becomes entitled to such benefits or the month in which he attains the age of eighteen, whichever is later, or, in the case of an individual entitled to widow's or widower's insurance benefits under section 202(e) or (f) who became entitled to such benefits prior to attaining age 60, with the month in which such individual becomes so entitled. Notwithstanding the preceding sentence, no period of trial work may begin for any individual prior to the beginning of the month following the month in which this paragraph is enacted[445]; and no such period may begin for an individual in a period of disability of such individual in which he had a previous period of trial work.

(4) A period of trial work for any individual shall end with the close of whichever of the following months is the earlier:

(A) the ninth month, in any period of 60 consecutive months,[446] in which the individual renders services (whether or not such nine months are consecutive); or

(B) the month in which his disability (as defined in section 223(d)) ceases (as determined after application of paragraph (2) of this subsection).

(5) **[**Stricken.[447]**]**

Costs of Rehabilitation Services From Trust Funds

(d)(1) For purposes of making vocational rehabilitation services more readily available to disabled individuals who are—

(A) entitled to disability insurance benefits under section 223,

(B) entitled to child's insurance benefits under section 202(d) after having attained age 18 (and are under a disability),

(C) entitled to widow's insurance benefits under section 202(e) prior to attaining age 60, or

(D) entitled to widower's insurance benefits under section 202(f) prior to attaining age 60, to the end that savings will accrue to the Trust Funds as a result of rehabilitating such individuals, there are authorized to be transferred from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund each fiscal year such sums as may be necessary to enable the Secretary to reimburse the State for the reasonable and necessary costs of vocational rehabilitation services furnished such individuals (including services during their waiting periods), under a State plan for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973[448] (29 U.S.C. 701 et seq.), (i) in cases where the furnishing of such services results in the performance by such individuals of substantial gainful activity for a continuous period of nine months, (ii) in cases where such individuals receive benefits as a result of section 225(b) (except that no reimbursement under this paragraph shall be made for services furnished to any individual receiving such benefits for any period after the close of such individual's ninth consecutive month of substantial gainful activity or the close of the month in which his or her entitlement to such benefits ceases, whichever first occurs), and (iii) in cases where such individuals, without good cause, refuse to continue to accept vocational rehabilitation services or fail to cooperate in such a manner as to preclude their successful rehabilitation. The determination that the vocational rehabilitation services contributed to the successful return of an individual to substantial gainful activity, the determination that an individual, without good cause, refused to continue to accept vocational rehabilitation services or failed to cooperate in such a manner as to preclude successful rehabilitation, and the determination of the amount of costs to be reimbursed under this subsection shall be made by the Commissioner of Social Security in accordance with criteria formulated by him.

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[445] The month is October 1960; the paragraph was enacted on September 13, 1960, as part of P.L. 86-778 [74 Stat. 968].

[446] P.L. 101-508, §5112(a)(1), struck out ", beginning on or after the first day of such period," and substituted ", in any period of 60 consecutive months,", effective January 1, 1992.

[447] P.L. 101-508, §5112(a)(2), struck out paragraph (5), effective January 1, 1992. **[**For paragraph (5) as it formerly read, Vol. III, P.L. 101-508.**]**

(2) In the case of any State which is unwilling to participate or does not have a plan which meets the requirements of paragraph (1), the Commissioner of Social Security may provide such services in such State by agreement or contract with other public or private agencies, organizations, institutions, or individuals. The provision of such services shall be subject to the same conditions as otherwise apply under paragraph (1).

(3) Payments under this subsection shall be made in advance or by way of reimbursement, with necessary adjustments for overpayments and underpayments.

(4) Money paid from the Trust Funds under this subsection for the reimbursement of the costs of providing services to individuals who are entitled to benefits under section 223 (including services during their waiting periods), or who are entitled to benefits under section 202(d) on the basis of the wages and self-employment income of such individuals, shall be charged to the Federal Disability Insurance Trust Fund, and all other money paid from the Trust Funds under this subsection shall be charged to the Federal Old-Age and Survivors Insurance Trust Fund. The Secretary shall determine according to such methods and procedures as he may deem appropriate—

(A) the total amount to be reimbursed for the cost of services under this subsection, and

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[448] P.L. 93-112.

(B) subject to the provisions of the preceding sentence, the amount which should be charged to each of the Trust Funds.

(5) For purposes of this subsection the term "vocational rehabilitation services" shall have the meaning assigned to it in title I of the Rehabilitation Act of 1973[449] (29 U.S.C. 701 et seq.), except that such services may be limited in type, scope, or amount in accordance with regulations of the Secretary designed to achieve the purpose of this subsection.

DISABILITY INSURANCE BENEFIT PAYMENTS[450]

Disability Insurance Benefits

SEC. 223. [42 U.S.C. 423] (a)(1) Every individual who—

(A) is insured for disability insurance benefits (as determined under subsection (c)(1)),

(B) has not attained retirement age (as defined in section 216(l)),

(C) has filed application for disability insurance benefits, and

(D) is under a disability (as defined in subsection (d))

shall be entitled to a disability insurance benefit (i) for each month beginning with the first month after his waiting period (as defined in subsection (c)(2)) in which he becomes so entitled to such insurance benefits, or (ii) for each month beginning with the first month during all of which he is under a disability and in which he becomes so entitled to such insurance benefits, but only if he was entitled to disability insurance benefits which terminated, or had a period of disability (as defined in section 216(i)) which ceased, within the 60-month period preceding the first month in which he is under such disability, and ending with the month preceding whichever of the following months is the earliest: the month in which he dies, the month in which he attains retirement age (as defined in section 216(l)), or, subject to subsection (e), the termination month. For purposes of the preceding sentence, the termination month for any individual shall be the third month following the month in which his disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 222(c)(4)(A), the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 36 months following such period of trial work in which he engages or is determined able to engage in substantial gainful activity. No payment under this paragraph may be made to an individual who would not meet the definition of disability in subsection (d) except for paragraph (1)(B) thereof for any month in which he engages in substantial gainful activity, and no payment may be made for such month under subsection (b), (c), or (d) of section 202 to any person on the basis of the wages and self-employment income of such individual. In the case of a deceased individual, the requirement of subparagraph (C) may be satisfied by an application for benefits filed with respect to such individual within 3 months after the month in which he died.

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[449] P.L. 93-112.

[450] See Vol. II, P.L. 96-265, §505(a) [as amended by P.L. 101-239], with respect to experiments and demonstration projects regarding work activity of disabled beneficiaries, and §505(c), with respect to the Secretary's report to Congress on the experiments and demonstration projects conducted.

See Vol. II, P.L. 97-248, §278(d), with respect to deemed entitlement for hospital insurance benefits purposes.

(2) Except as provided in section 202(q) and section 215(b)(2)(A)(ii), such individual's disability insurance benefit for any month shall be equal to his primary insurance amount for such month determined under section 215 as though he had attained age 62 in—

(A) the first month of his waiting period, or

(B) in any case in which clause (ii) of paragraph (1) of this subsection is applicable, the first month for which he becomes entitled to such disability insurance benefits,

and as though he had become entitled to old-age insurance benefits in the month in which the application for disability insurance benefits was filed and he was entitled to an old-age insurance benefit for each month for which (pursuant to subsection (b)) he was entitled to a disability insurance benefit. For the purposes of the preceding sentence, in the case of an individual who attained age 62 in or before the first month referred to in subparagraph (A) or (B) of such sentence, as the case may be, the elapsed years referred to in section 215(b)(3) shall not include the year in which he attained age 62, or any year thereafter.

Filing of Application

(b) An application for disability insurance benefits filed before the first month in which the applicant satisfies the requirements for such benefits (as prescribed in subsection (a)(1)) shall be deemed a valid application (and shall be deemed to have been filed in such first month) only if the applicant satisfies the requirements for such benefits before the Secretary makes a final decision on the application and no request under section 205(b) for notice and opportunity for a hearing thereon is made, or if such a request is made, before a decision based upon the evidence adduced at the hearing is made (regardless of whether such decision becomes the final decision of the Secretary). An individual who would have been entitled to a disability insurance benefit for any month had he filed application therefor before the end of such month shall be entitled to such benefit for such month if such application is filed before the end of the 12th month immediately succeeding such month.

Definitions of Insured Status and Waiting Period

(c) For purposes of this section—

(1) An individual shall be insured for disability insurance benefits in any month if—

(A) he would have been a fully insured individual (as defined in section 214) had he attained age 62 and filed application for benefits under section 202(a) on the first day of such month, and

(B)(i) he had not less than 20 quarters of coverage during the 40-quarter period which ends with the quarter in which such month occurred, or

(ii) if such month ends before the quarter in which he attains (or would attain) age 31, not less than one-half (and not less than 6) of the quarters during the period ending with the quarter in which such month occurred and beginning after he attained the age of 21 were quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter were quarters of coverage, or

(iii) in the case of an individual (not otherwise insured under clause (i)) who, by reason of section 216(i)(3)(B)(ii), had a prior period of disability that began during a period before the quarter in which he or she attained age 31, not less than one-half of the quarters beginning after such individual attained age 21 and ending with the quarter in which such month occurs are quarters of coverage, or (if the number of quarters in such period is less than 12) not less than 6 of the quarters in the 12-quarter period ending with such quarter are quarters of coverage;

except that the provisions of subparagraph (B) of this paragraph shall not apply in the case of an individual who is blind (within the meaning of "blindness" as defined in section 216(i)(1)). For purposes of subparagraph (B) of this paragraph, when the number of quarters in any period is an odd number, such number shall be reduced by one, and a quarter shall not be counted as part of any period if any part of such quarter was included in a period of disability unless such quarter was a quarter of coverage.

(2) The term "waiting period" means, in the case of any application for disability insurance benefits, the earliest period of five consecutive calendar months—

(A) throughout which the individual with respect to whom such application is filed has been under a disability, and

(B)(i) which begins not earlier than with the first day of the seventeenth month before the month in which such application is filed if such individual is insured for disability insurance benefits in such seventeenth month, or (ii) if he is not so insured in such month, which begins not earlier than with the first day of the first month after such seventeenth month in which he is so insured.

Notwithstanding the preceding provisions of this paragraph, no waiting period may begin for any individual before January 1, 1957.

Definition of Disability

(d)(1) The term "disability" means—

(A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or

(B) in the case of an individual who has attained the age of 55 and is blind (within the meaning of "blindness" as defined in section 216(i)(1)), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.

(2) For purposes of paragraph (1)(A)—

(A) An individual[451] shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

(B)[452] In determining whether an individual's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under this section, the Secretary shall consider the combined effect of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity. If the Secretary does find a medically severe combination of impairments, the combined impact of the impairments shall be considered throughout the disability determination process.

(3) For purposes of this subsection, a "physical or mental impairment" is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

(4) The Secretary shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. No individual who is blind shall be regarded as having demonstrated an ability to engage in substantial gainful activity on the basis of earnings that do not exceed the exempt amount under section 203(f)(8) which is applicable to individuals described in subparagraph (D) thereof. Notwithstanding the provisions of paragraph (2), an individual whose services or earnings meet such criteria shall, except for purposes of section 222(c), be found not to be disabled. In determining whether an individual is able to engage in substantial gainful activity by reason of his earnings, where his disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, there shall be excluded from such earnings an amount equal to the cost (to such

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[451] P.L. 101-508, §5103(a)(1), struck out "(except a widow, surviving divorced wife, widower, or surviving divorced husband for purposes of section 202(e) or (f))", applicable to monthly insurance benefits for months after December 1990 for which applications are filed on or after January 1, 1991, or are pending on such date.

[452] P.L. 101-508, §5103(a)(2), struck out subparagraph (B), applicable to monthly insurance benefits for months after December 1990 for which applications are filed on or after January 1, 1991, or are pending on such date. [For subparagraph (B) as it formerly read, see Vol. III, P.L. 101-508.]

P.L. 101-508, §5103(a)(3), redesignated subparagraph (C) as subparagraph (B).

individual) of any attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary (as determined by the Secretary in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions; except that the amounts to be excluded shall be subject to such reasonable limits as the Secretary may prescribe.

(5)(A) An individual shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the Secretary may require. An individual's statement as to pain or other symptoms shall not alone be conclusive evidence of disability as defined in this section; there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability. Objective medical evidence of pain or other symptoms established by medically acceptable clinical or laboratory techniques (for example, deteriorating nerve or muscle tissue) must be considered in reaching a conclusion as to whether the individual is under a disability. Any non-Federal hospital, clinic, laboratory, or other provider of medical services, or physician not in the employ of the Federal Government, which supplies medical evidence required and requested by the Secretary under this paragraph shall be entitled to payment from the Secretary for the reasonable cost of providing such evidence.

(B) In making any determination with respect to whether an individual is under a disability or continues to be under a disability, the Secretary shall consider all evidence available in such individual's case record, and shall develop a complete medical history of at least the preceding twelve months for any case in which a determination is made that the individual is not under a disability. In making any determination the Secretary shall make every reasonable effort to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic tests, necessary in order to properly make such determination, prior to evaluating medical evidence obtained from any other source on a consultative basis.

(6)(A) Notwithstanding any other provision of this title, any physical or mental impairment which arises in connection with the commission by an individual (after the date of the enactment of this paragraph[453]) of an offense which constitutes a felony under applicable law and for which such individual is subsequently convicted, or which is aggravated in connection with such an offense (but only to the extent so aggravated), shall not be considered in determining whether an individual is under a disability.

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[453] This paragraph was enacted on October 19, 1980 [P.L. 96-473; 94 Stat. 2263].

(B) Notwithstanding any other provision of this title, any physical or mental impairment which arises in connection with an individual's confinement in a jail, prison, or other penal institution or correctional facility pursuant to such individual's conviction of an offense (committed after the date of the enactment of this paragraph) constituting a felony under applicable law, or which is aggravated in connection with such a confinement (but only to the extent so aggravated), shall not be considered in determining whether such individual is under a disability for purposes of benefits payable for any month during which such individual is so confined.

(e)(1) [454] No benefit shall be payable under subsection (d)(1)(B)(ii), (d)(6)(A)(ii), (d)(6)(B), (e)(1)(B)(ii), or (f)(1)(B)(ii) of section 202 or under subsection (a)(1) of this section to an individual for any month, after the third month, in which he engages in substantial gainful activity during the 36-month period following the end of his trial work period determined by application of section 222(c)(4)(A).

(2) No benefit shall be payable under section 202 on the basis of the wages and self-employment income of an individual entitled to a benefit under subsection (a)(1) of this section for any month for which the benefit of such individual under subsection (a)(1) is not payable under paragraph (1).[455]

Standard of Review for Termination of Disability Benefits

(f) A recipient of benefits under this title or title XVIII based on the disability of any individual may be determined not to be entitled to such benefits on the basis of a finding that the physical or mental impairment on the basis of which such benefits are provided has ceased, does not exist, or is not disabling only if such finding is supported by—

(1) substantial evidence which demonstrates that—

(A) there has been any medical improvement in the individual's impairment or combination of impairments (other than medical improvement which is not related to the individual's ability to work), and

(B) the individual is now able to engage in substantial gainful activity; or[456]

(2) substantial evidence which—

(A) consists of new medical evidence and (in a case to which clause (ii)(II) does not apply) a new assessment of the individual's residual functional capacity, and demonstrates that—

(i) although the individual has not improved medically, he or she is nonetheless a beneficiary of advances in medical or vocational therapy or technology (related to the individual's ability to work), and

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[454] P.L. 101-508, §5118(a)(1), redesignated subsection (e) as subparagraph (1), applicable to benefits for months after November 5, 1990.

[455] P.L. 101-508, §5118(a)(2), added paragraph (2), applicable to benefits for months after November 5, 1990.

[456] P.L. 101-508, §5103(b)(2), amended subparagraph (B) in its entirety, applicable to monthly insurance benefits for months after December 1990 for which applications are filed on or after January 1, 1991, or are pending on such date. **[**For subparagraph (B) as it formerly read, see Vol. *III, P.L. 101-508.***]**

(ii) the individual is now able to engage in substantial gainful activity, or[457]

(B) demonstrates that—

(i) although the individual has not improved medically, he or she has undergone vocational therapy (related to the individual's ability to work), and

(ii) the requirements of subclause (I) or (II) of subparagraph (A)(ii) are met; or

(3) substantial evidence which demonstrates that, as determined on the basis of new or improved diagnostic techniques or evaluations, the individual's impairment or combination of impairments is not as disabling as it was considered to be at the time of the most recent prior decision that he or she was under a disability or continued to be under a disability, and that therefore the individual is able to engage in substantial gainful activity; or[458]

(4) substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) which demonstrates that a prior determination was in error.

Nothing in this subsection shall be construed to require a determination that a recipient of benefits under this title or title XVIII based on an individual's disability is entitled to such benefits if the prior determination was fraudulently obtained or if the individual is engaged in substantial gainful activity[459], cannot be located, or fails, without good cause, to cooperate in a review of the entitlement to such benefits or to follow prescribed treatment which would be expected to restore his or her ability to engage in substantial gainful activity[460]. In making for purposes of the preceding sentence any determination relating to fraudulent behavior by any individual or failure by any individual without good cause to cooperate or to take any required action, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).[461] Any determination under this section shall be made on the basis of all the evidence available in the individual's case file, including new evidence concerning the individual's prior or current condition which is presented by the individual or secured by the Secretary. Any determination made under this section shall be made on the basis of the weight of the evidence and on a neutral basis with regard to the individual's condition, without any initial inference as to the presence or absence of disability being drawn from the fact that the individual has previously been determined to be disabled. For purposes of this subsection, a benefit under this title is based on an individual's disability if it is a disability insurance benefit, a child's, widow's, or widower's insurance benefit based on disability, or a mother's or father's insurance benefit based on the disability of the mother's or father's child who has attained age 16.

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[457] P.L. 101-508, §5103(b)(3), amended clause (ii) in its entirety, applicable to monthly insurance benefits for months after December 1990 for which applications are filed on or after January 1, 1991, or are pending on such date. [For clause (ii) as it formerly read, see Vol. III, P.L. 101-508.]

[458] P.L. 101-508, §5103(b)(4), struck out "therefore—" and subparagraphs (A) and (B) and substituted "therefore the individual is able to engage in substantial gainful activity; or", applicable to monthly insurance benefits for months after December 1990 for which applications are filed on or after January 1, 1991, or are pending on such date. [For subparagraphs (A) and (B) as they formerly read, see Vol. III, P.L. 101-508.]

[459] P.L. 101-508, §5103(b)(5), struck out "(or gainful activity in the case of a widow, surviving divorced wife, widower, or surviving divorced husband)", applicable to monthly insurance benefits for months after December 1990 for which applications are filed on or after January 1, 1991, or are pending on such date.

[460] P.L. 101-508, §5103(b)(5), struck out "(or gainful activity in the case of a widow, surviving divorced wife, widower, or surviving divorced husband)", applicable to monthly insurance benefits for months after December 1990 for which applications are filed on or after January 1, 1991, or are pending on such date..

[461] P.L. 101-239, §10305(c), added this sentence, applicable with respect to determinations made on or after July 1, 1990.

Continued Payment of Disability Benefits During Appeal

(g)(1) In any case where—

(A) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurance benefits based on disability,

(B) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and as a consequence such individual is determined not to be entitled to such benefits, and

(C) a timely request for a hearing under section 221(d), or for an administrative review prior to such hearing, is pending with respect to the determination that he is not so entitled,

such individual may elect (in such manner and form and within such time as the Secretary shall by regulations prescribe) to have the payment of such benefits, the payment of any other benefits under this title based on such individual's wages and self-employment income, the payment of mother's or father's insurance benefits to such individual's mother or father based on the disability of such individual as a child who has attained age 16, and the payment of benefits under title XVIII based on such individual's disability, continued for an additional period beginning with the first month beginning after the date of the enactment of this subsection[462] for which (under such determination) such benefits are no longer otherwise payable, and ending with the earlier of (i) the month preceding the month in which a decision is made after such a hearing, or[463](ii) the month preceding the month in which no such request for a hearing or an administrative review is pending[464].

(2)(A) If an individual elects to have the payment of his benefits continued for an additional period under paragraph (1), and the final decision of the Secretary affirms the determination that he is not entitled to such benefits, any benefits paid under this title pursuant to such election (for months in such additional period) shall be considered overpayments for all purposes of this title, except as otherwise provided in subparagraph (B).

(B) If the Secretary determines that the individual's appeal of his termination of benefits was made in good faith, all of the benefits paid pursuant to such individual's election under paragraph (1) shall be subject to waiver consideration under the provisions of section 204. In making for purposes of this subparagraph any determination of whether any individual's appeal is made in good faith, the Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation such individual may have (including any lack of facility with the English language).[465]

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[462] This subsection was enacted on January 12, 1983 [P.L. 97-455; 96 Stat. 2497].

[463] P.L. 101-508, §5102(1), inserted "or", effective November 5, 1990.

[464] P.L. 101-508, §5102(1), struck out ", or (iii) June 1991", effective November 5, 1990.

(3) [Stricken.[466]]

Interim Benefits in Cases of Delayed Final Decisions[467]

(h)(1) In any case in which an administrative law judge has determined after a hearing as provided under section 205(b) that an individual is entitled to disability insurance benefits or child's, widow's, or widower's insurance benefits based on disability and the Secretary has not issued his final decision in such case within 110 days after the date of the administrative law judge's determination, such benefits shall be currently paid for the months during the period beginning with the month preceding the month in which such 110-day period expires and ending with the month preceding the month in which such final decision is issued.

(2) For purposes of paragraph (1), in determining whether the 110-day period referred to in paragraph (1) has elapsed, any period of time for which the action or inaction of such individual or such individual's representative without good cause results in the delay in the issuance of the Secretary's final decision shall not be taken into account to the extent that such period of time exceeds 20 calendar days.

(3) Any benefits currently paid under this title pursuant to this subsection (for the months described in paragraph (1)) shall not be considered overpayments for any purpose of this title (unless payment of such benefits was fraudulently obtained), and such benefits shall not be treated as past-due benefits for purposes of section 206(b)(1).

(i)[468] For provisions relating to limitation on payments to prisoners, see section 202(x).

REDUCTION OF BENEFITS BASED ON DISABILITY

SEC. 224. [42 U.S.C. 424a] (a) If for any month prior to the month in which an individual attains the age of 65—

- (1) such individual is entitled to benefits under section 223, and
- (2) such individual is entitled for such month to—
  - (A) periodic benefits on account of his or her total or partial disability (whether or not permanent) under a workmen's compensation law or plan of the United States or a State, or
  - (B) periodic benefits on account of his or her total or partial disability (whether or not permanent) under any other law or plan of the United States, a State, a political subdivision (as that term is used in section 218(b)(2)), or an instrumentality of two or more States (as that term is used in section 218(g)), other than (i) benefits payable under title 38, United States Code, (ii) benefits payable under a program

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[465] P.L. 101-239, §10305(d), added this sentence, applicable with respect to determinations made on or after July 1, 1990.

[466] P.L. 101-508, §5102(2), struck out paragraph (3), effective November 5, 1990. [For paragraph (3) as it formerly read, see Vol. III, P.L. 101-508.]

[467] P.L. 100-647, §8001(a)(2) added this subsection (h), applicable to determinations by administrative law judges of entitlement to benefits made after May 9, 1989.

[468] P.L. 100-647, §8001(a)(1), redesignated subsection (h) as subsection (i).

of assistance which is based on need, (iii) benefits based on service all or substantially all of which was included under an agreement entered into by a State and the Secretary under section 218, and (iv) benefits under a law or plan of the United States based on service all or substantially all of which is employment as defined in section 210,

the total of his benefits under section 223 for such month and of any benefits under section 202 for such month based on his wages and self-employment income shall be reduced (but not below zero) by the amount by which the sum of—

(3) such total of benefits under sections 223 and 202 for such month, and

(4) such periodic benefits payable (and actually paid) for such month to such individual under such laws or plans,

exceeds the higher of—

(5) 80 per centum of his "average current earnings", or

(6) the total of such individual's disability insurance benefits under section 223 for such month and of any monthly insurance benefits under section 202 for such month based on his wages and self-employment income, prior to reduction under this section.

In no case shall the reduction in the total of such benefits under sections 223 and 202 for a month (in a continuous period of months) reduce such total below the sum of—

(7) the total of the benefits under sections 223 and 202, after reduction under this section, with respect to all persons entitled to benefits on the basis of such individual's wages and self-employment income for such month which were determined for such individual and such persons for the first month for which reduction under this section was made (or which would have been so determined if all of them had been so entitled in such first month), and

(8) any increase in such benefits with respect to such individual and such persons, before reduction under this section, which is made effective for months after the first month for which reduction under this section is made.

For purposes of clause (5), an individual's average current earnings means the largest of (A) the average monthly wage (determined under section 215(b) as in effect prior to January 1979) used for purposes of computing his benefits under section 223, (B) one-sixtieth of the total of his wages and self-employment income (computed without regard to the limitations specified in sections 209(a)(1)[469] and 211(b)(1)) for the five consecutive calendar years after 1950 for which such wages and self-employment income were highest, or (C) one-twelfth of the total of his wages and self-employment income (computed without regard to the limitations specified in sections 209(a)(1)[470] and 211(b)(1)) for the calendar year in which he had the highest such wages and income during the period consisting of the calendar year in which he became disabled (as defined in section 223(d)) and the five years preceding that year.

(b) If any periodic benefit for a total or partial disability under a law or plan described in subsection (a)(2) is payable on other than a monthly basis (excluding a benefit payable as a lump sum except to the extent that it is a commutation of, or a substitute for, periodic payments), the reduction under this section shall be made at such time or times and in such amounts as the Secretary finds will approximate as nearly as practicable the reduction prescribed by subsection (a).

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[469] P.L. 101-239, §10208(d)(2)(A)(iii), inserted "(1)", effective December 19, 1989.

[470] P.L. 101-239, §10208(d)(2)(A)(iii), inserted "(1)", effective December 19, 1989.

(c) Reduction of benefits under this section shall be made after any reduction under subsection (a) of section 203, but before deductions under such section and under section 222(b).

(d) The reduction of benefits required by this section shall not be made if the law or plan described in subsection (a)(2) under which a periodic benefit is payable provides for the reduction thereof when anyone is entitled to benefits under this title on the basis of the wages and self-employment income of an individual entitled to benefits under section 223, and such law or plan so provided on February 18, 1981.

(e) If it appears to the Secretary that an individual may be eligible for periodic benefits under a law or plan which would give rise to reduction under this section, he may require, as a condition of certification for payment of any benefits under section 223 to any individual for any month and of any benefits under section 202 for such month based on such individual's wages and self-employment income, that such individual certify (i) whether he has filed or intends to file any claim for such periodic benefits, and (ii) if he has so filed, whether there has been a decision on such claim. The Secretary may, in the absence of evidence to the contrary, rely upon such a certification by such individual that he has not filed and does not intend to file such a claim, or that he has so filed and no final decision thereon has been made, in certifying benefits for payment pursuant to section 205(i).

(f)(1) In the second calendar year after the year in which reduction under this section in the total of an individual's benefits under section 223 and any benefits under section 202 based on his wages and self-employment income was first required (in a continuous period of months), and in each third year thereafter, the Secretary shall redetermine the amount of such benefits which are still subject to reduction under this section; but such redetermination shall not result in any decrease in the total amount of benefits payable under this title on the basis of such individual's wages and self-employment income. Such redetermined benefit shall be determined as of, and shall become effective with, the January following the year in which such redetermination was made.

(2) In making the redetermination required by paragraph (1), the individual's average current earnings (as defined in subsection (a)) shall be deemed to be the product of—

(A) his average current earnings as initially determined under subsection (a);

(B) the ratio of (i) the deemed average total wages (as defined in section 209(k)(1))[471] for the calendar year before the year in which such redetermination is made to (ii)(I)[472] the average of the total wages ([473] (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1))[474] reported to the Secretary of the Treasury or his delegate for calendar year 1977 or, if later, the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability), if such calendar year is before 1991, or (II) the deemed average total wages (as defined in section 209(k)(1)) for the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability), if such calendar year is after 1990[475]; and

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[471] P.L. 101-239, §10208(b)(2)(A), struck out "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1)[*]) reported to the Secretary of the Treasury or his delegate" and substituted "the deemed average total wages (as defined in section 209(k)(1))", applicable with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

[*] P.L. 101-239, §10208(d)(2)(A)(i), struck out "209(a)" and substituted "209(a)(1)", effective December 19, 1989.

(C) in any case in which the reduction was first computed before 1978, the ratio of (i) the average of the taxable wages reported to the Secretary for the first calendar quarter of 1977 to (ii) the average of the taxable wages reported to the Secretary for the first calendar quarter of the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability).

Any amount determined under this paragraph which is not a multiple of $1 shall be reduced to the next lower multiple of $1.

(g) Whenever a reduction in the total of benefits for any month based on an individual's wages and self-employment income is made under this section, each benefit, except the disability insurance benefit, shall first be proportionately decreased, and any excess of such reduction over the sum of all such benefits other than the disability insurance benefits shall then be applied to such disability insurance benefit.

(h)(1) Notwithstanding any other provision of law, the head of any Federal agency shall provide such information within its possession as the Secretary may require for purposes of making a timely determination of the amount of the reduction, if any, required by this section in benefits payable under this title, or verifying other information necessary in carrying out the provisions of this section.

(2) The Secretary is authorized to enter into agreements with States, political subdivisions, and other organizations that administer a law or plan subject to the provisions of this section, in order to obtain such information as he may require to carry out the provisions of this section.

SUSPENSION OF BENEFITS BASED ON DISABILITY

SEC. 225. [42 U.S.C. 425] (a) If the Secretary, on the basis of information obtained by or submitted to him, believes that an individual entitled to benefits under section 223, or that a child who has attained the age of eighteen and is entitled to benefits under section 202(d), or that a widow or surviving divorced wife who has not attained age 60 and is entitled to benefits under section 202(e), or that a widower or surviving divorced husband who has not attained age 60 and is entitled to benefits under section 202(f), may have ceased to be under a disability, the Secretary may suspend the payment of benefits under such section 202(d), 202(e), 202(f), or 223 until it is determined (as provided in section 221) whether or not such individual's disability has ceased or until the Secretary believes that such disability has not ceased. In the case of any individual whose disability is subject to determination under an agreement with a State under section 221(b), the Secretary shall promptly notify the appropriate State of his action under this subsection and shall request a prompt determination of whether such individual's disability has ceased. For purposes of this subsection, the term "disability" has the meaning assigned to such term in section 223(d). Whenever the benefits of an individual entitled to a disability insurance benefit are suspended for any month, the benefits of any individual entitled thereto under subsection (b), (c), or (d) of section 202, on the basis of the wages and self-employment income of such individual, shall be suspended for such month. The first sentence of this subsection shall not apply to any child entitled to benefits under section 202(d), if he has attained the age of 18 but has not attained the age of 22, for any month during which he is a full-time student (as defined and determined under section 202(d)).

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[472] P.L. 101-239, §10208(b)(2)(C), inserted "(I)".

[473] As in original. One parenthesis should be stricken.

[474] P.L. 101-239, §10208(b)(2)(C), struck out "as so defined and computed)" and substituted "(as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1))", applicable with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

[475] P.L. 101-239, §10208(b)(2)(C), inserted ", if such calendar year is before 1991, or" and subclause (II), applicable with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

(b) Notwithstanding any other provision of this title, payment to an individual of benefits based on disability (as described in the first sentence of subsection (a)) shall not be terminated or suspended because the physical or mental impairment, on which the individual's entitlement to such benefits is based, has or may have ceased, if—

(1) such individual is participating in a program of vocational rehabilitation services approved by the Secretary, and[476]

(2) the Secretary[477] determines that the completion of such program, or its continuation for a specified period of time, will increase the likelihood that such individual may (following his participation in such program) be permanently removed from the disability benefit rolls.

ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS[478]

SEC. 226. [42 U.S.C. 426] (a) Every individual who—

(1) has attained age 65, and

(2)(A) is entitled to monthly insurance benefits under section 202, would be entitled to those benefits except that he has not filed an application therefor (or application has not been made for a benefit the entitlement to which for any individual is a condition of entitlement therefor), or would be entitled to such benefits but for the failure of another individual, who meets all the criteria of entitlement to monthly insurance benefits, to meet such criteria throughout a month, and, in conformity with regulations of the Secretary, files an application for hospital insurance benefits under part A of title XVIII,

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[476] P.L. 101-508, §5113(a)(1), amended paragraph (1) in its entirety, effective with benefits payable for months after October 1991, and applicable only with respect to individuals whose blindness or disability has or may have ceased after October 1991. [For paragraph (1) as it formerly read, see Vol. III, P.L. 101-508.]

[477] P.L. 101-508, §5113(a)(2), struck out "Commissioner of Social Security" and substituted "Secretary", effective with benefits payable for months after October 1991, and applicable only with respect to individuals whose blindness or disability has or may have ceased after October 1991.

[478] See Vol. II, P.L. 97-248, §278(d), with respect to deemed entitlement for hospital insurance benefits purposes.

(B) is a qualified railroad retirement beneficiary, or

(C)(i) would meet the requirements of subparagraph (A) upon filing application for the monthly insurance benefits involved if medicare qualified government employment (as defined in section 210(p)) were treated as employment (as defined in section 210(a)) for purposes of this title, and (ii) files an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of title XVIII,

shall be entitled to hospital insurance benefits under part A of title XVIII for each month for which he meets the condition specified in paragraph (2), beginning with the first month after June 1966 for which he meets the conditions specified in paragraphs (1) and (2).

(b) Every individual who—

(1) has not attained age 65, and

(2)(A) is entitled to, and has for 24 calendar months been entitled to, (i) disability insurance benefits under section 223 or (ii) child's insurance benefits under section 202(d) by reason of a disability (as defined in section 223(d)) or (iii) widow's insurance benefits under section 202(e) or widower's insurance benefits under section 202(f) by reason of a disability (as defined in section 223(d)), or

(B) is, and has been for not less than 24 months, a disabled qualified railroad retirement beneficiary, within the meaning of section 7(d) of the Railroad Retirement Act of 1974[479], or

(C)(i) has filed an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of title XVIII pursuant to this subparagraph, and

(ii) would meet the requirements of subparagraph (A) (as determined under the disability criteria, including reviews, applied under this title), including the requirement that he has been entitled to the specified benefits for 24 months, if—

(I) medicare qualified government employment (as defined in section 210(p)) were treated as employment (as defined in section 210(a)) for purposes of this title, and

(II) the filing of the application under clause (i) of this subparagraph were deemed to be the filing of an application for the disability-related benefits referred to in clause (i), (ii), or (iii) of subparagraph (A),

shall be entitled to hospital insurance benefits under part A of title XVIII for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and ending (subject to the last sentence of this subsection) with the month following the month in which notice of termination of such entitlement to benefits or status as a qualified railroad retirement beneficiary described in paragraph (2) is mailed to him, or if earlier, with the month before the month in which he attains age 65. In applying the previous sentence in the case of an individual described in paragraph (2)(C), the "twenty-fifth month of his entitlement" refers to the first month after the twenty-fourth month of entitlement to specified benefits referred to in paragraph (2)(C) and "notice of termination of such entitlement" refers to a notice that the individual would no longer be determined to be entitled to such specified benefits under the conditions described in that paragraph. For purposes of this subsection, an individual who has had a period of trial work which ended as provided in section 222(c)(4)(A), and whose entitlement to benefits or status as a qualified railroad retirement beneficiary as described in paragraph (2) has subsequently terminated, shall be deemed to be entitled to such benefits or to occupy such status (notwithstanding the termination of such entitlement or status) for the period of consecutive months throughout all of which the physical or mental impairment, on which such entitlement or status was based, continues, and throughout all of which such individual would have been entitled to monthly insurance benefits under title II or as a qualified railroad retirement beneficiary had such individual been unable to engage in substantial gainful activity, but not in excess of 24 such months. In determining when an individual's entitlement or status terminates for purposes of the preceding sentence, the term "36 months" in the second sentence of section 223(a)(1), in section 202(d)(1)(G)(i), in the last sentence of section 202(e)(1), and in the last sentence of section 202(f)(1) shall be applied as though it read "15 months".

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[479] P.L. 75-162 [as amended by P.L. 93-445].

(c) For purposes of subsection (a)—

(1) entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, part A of title XVIII on his behalf for inpatient hospital services, post-hospital extended care services, and home health services (as such terms are defined in part C of title XVIII) furnished him in the United States (or outside the United States in the case of inpatient hospital services furnished under the conditions described in section 1814(f)) during such month; except that (A) no such payment may be made for post-hospital extended care services furnished before January 1967, and (B) no such payment may be made for post-hospital extended care services unless the discharge from the hospital required to qualify such services for payment under part A of title XVIII occurred (i) after June 30, 1966, or on or after the first day of the month in which he attains age 65, whichever is later, or (ii) if he was entitled to hospital insurance benefits pursuant to subsection (b), at a time when he was so entitled; and

(2) an individual shall be deemed entitled to monthly insurance benefits under section 202 or section 223, or to be a qualified railroad retirement beneficiary, for the month in which he died if he would have been entitled to such benefits, or would have been a qualified railroad retirement beneficiary, for such month had he died in the next month.

(d) For purposes of this section, the term "qualified railroad retirement beneficiary" means an individual whose name has been certified to the Secretary by the Railroad Retirement Board under section 7(d) of the Railroad Retirement Act of 1974[480]. An individual shall cease to be a qualified railroad retirement beneficiary at the close of the month preceding the month which is certified by the Railroad Retirement Board as the month in which he ceased to meet the requirements of section 7(d) of the Railroad Retirement Act of 1974.

(e)(1)(A)[481] For purposes of determining entitlement to hospital insurance benefits under subsection (b) in the case of widows and widowers described in paragraph (2)(A)(iii) thereof—

(i)[482] the term "age 60" in sections 202(e)(1)(B)(ii), 202(e)(4), 202(f)(1)(B)(ii), and 202(f)(5) shall be deemed to read "age 65"; and

(ii)[483] the phrase "before she attained age 60" in the matter following subparagraph (F) of section 202(e)(1) and the phrase "before he attained age 60" in the matter following subparagraph (F) of section 202(f)(1) shall each be deemed to read "based on a disability".

(B) For purposes of subsection (b)(2)(A)(iii), each month in the period commencing with the first month for which an individual is first eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) of this Act (or payments of the type described in section 212(a) of Public Law 93-66) which are paid by the Secretary under an agreement referred to in section 1616(a) (or in section 212(b) of Public Law 93-66), shall be included as one of the 24 months for which such individual must have been entitled to widow's or widower's insurance benefits on the basis of disability in order to become entitled to hospital insurance benefits on that basis.[484]

(2) For purposes of determining entitlement to hospital insurance benefits under subsection (b) in the case of an individual under age 65 who is entitled to benefits under section 202, and who was entitled to widow's insurance benefits or widower's insurance benefits based on disability for the month before the first month in which such individual was so entitled to old-age insurance benefits (but ceased to be entitled to such widow's or widower's insurance benefits upon becoming entitled to such old-age insurance benefits), such individual shall be deemed to have continued to be entitled to such widow's insurance benefits or widower's insurance benefits for and after such first month.

(3) For purposes of determining entitlement to hospital insurance benefits under subsection (b), any disabled widow aged 50 or older who is entitled to mother's insurance benefits (and who would have been entitled to widow's insurance benefits by reason of disability if she had filed for such widow's benefits), and any disabled widower aged 50 or older who is entitled to father's insurance benefits (and who would have been entitled to widower's insurance benefits by reason of disability if he had filed for such widower's benefits), shall, upon application for such hospital insurance benefits be deemed to have filed for such widow's or widower's insurance benefits.[485]

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[480] P.L. 75-162 [as amended by P.L. 93-445].

[481] P.L. 101-508, §5103(c)(2)(C)(ii), inserted "(A)".

[482] P.L. 101-508, §5103(c)(2)(C)(i), redesignated subparagraph (A) as clause (i).

[483] P.L. 101-508, §5103(c)(2)(C)(i), redesignated subparagraph (B) as clause (ii).

[484] P.L. 101-508, §5103(c)(2)(C)(iii), added subparagraph (B), applicable to items and services furnished after December 1990.

[485] See Vol. II, P.L. 98-21, "Social Security Amendments of 1983", §309(q)(2), with respect to determining entitlement to hospital insurance benefits in certain cases.

(4) For purposes of determining entitlement to hospital insurance benefits under subsection (b) in the case of an individual described in clause (iii) of subsection (b)(2)(A), the entitlement of such individual to widow's or widower's insurance benefits under section 202(e) or (f) by reason of a disability shall be deemed to be the entitlement to such benefits that would result if such entitlement were determined without regard to the provisions of section 202(j)(4).

(f) For purposes of subsection (b) (and for purposes of section 1837(g)(1) of this Act and section 7(d)(2)(ii) of the Railroad Retirement Act of 1974[486]), the 24 months for which an individual has to have been entitled to specified monthly benefits on the basis of disability in order to become entitled to hospital insurance benefits on such basis effective with any particular month (or to be deemed to have enrolled in the supplementary medical insurance program, on the basis of such entitlement, by reason of section 1837(f)), where such individual had been entitled to specified monthly benefits of the same type during a previous period which terminated—

(1) more than 60 months before the month in which his current disability began in any case where such monthly benefits were of the type specified in clause (A)(i) or (B) of subsection (b)(2), or

(2) more than 84 months before the month in which his current disability began in any case where such monthly benefits were of the type specified in clause (A)(ii) or (A)(iii) of such subsection,

shall not include any month which occurred during such previous period, unless the physical or mental impairment which is the basis for disability is the same as (or directly related to) the physical or mental impairment which served as the basis for disability in such previous period.

(g) The Secretary and Director of the Office of Personnel Management shall jointly prescribe and carry out procedures designed to assure that all individuals who perform medicare qualified government employment by virtue of service described in section 210(a)(5) are fully informed with respect to (1) their eligibility or potential eligibility for hospital insurance benefits (based on such employment) under part A of title XVIII, (2) the requirements for and conditions of such eligibility, and (3) the necessity of timely application as a condition of entitlement under subsection (b)(2)(C), giving particular attention to individuals who apply for an annuity under chapter 83 of title 5, United States Code, or under another similar Federal retirement program, and whose eligibility for such an annuity is or would be based on a disability.

(h) For entitlement to hospital insurance benefits in the case of certain uninsured individuals, see section 103 of the Social Security Amendments of 1965[487].

SPECIAL PROVISIONS RELATING TO COVERAGE UNDER MEDICARE PROGRAM FOR END STAGE RENAL DISEASE[488]

SEC. 226A. [42 U.S.C. 426-1] (a) Notwithstanding any provision to the contrary in section 226 or title XVIII, every individual who—

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[486] P.L. 75-162 [as amended by P.L. 93-445].

[487] P.L. 89-97.

[488] See Vol. II, P.L. 97-248, §278(d), with respect to deemed entitlement for hospital insurance benefits purposes.

(1)(A) is fully or currently insured (as such terms are defined in section 214), or would be fully or currently insured if (i) his service as an employee (as defined in the Railroad Retirement Act of 1974[489]) after December 31, 1936, were included within the meaning of the term "employment" for purposes of this title, and (ii) his medicare qualified government employment (as defined in section 210(p)) were included within the meaning of the term "employment" for purposes of this title;

(B)(i) is entitled to monthly insurance benefits under this title, (ii) is entitled to an annuity under the Railroad Retirement Act of 1974[490], or (iii) would be entitled to a monthly insurance benefit under this title if medicare qualified government employment (as defined in section 210(p)) were included within the meaning of the term "employment" for purposes of this title; or

(C) is the spouse or dependent child (as defined in regulations) of an individual described in subparagraph (A) or (B);

(2) is medically determined to have end stage renal disease; and

(3) has filed an application for benefits under this section;

shall, in accordance with the succeeding provisions of this section, be entitled to benefits under part A and eligible to enroll under part B of title XVIII, subject to the deductible, premium, and coinsurance provisions of that title.

(b) Subject to subsection (c), entitlement of an individual to benefits under part A and eligibility to enroll under part B of title XVIII by reasons of this section on the basis of end stage renal disease—

(1) shall begin with—

(A) the third month after the month in which a regular course of renal dialysis is initiated, or

(B) the month in which such individual receives a kidney transplant, or (if earlier) the first month in which such individual is admitted as an inpatient to an institution which is a hospital meeting the requirements of section 1861(e) (and such additional requirements as the Secretary may prescribe under section 1881(b) for such institutions) in preparation for or anticipation of kidney transplantation, but only if such transplantation occurs in that month or in either of the next two months,

whichever first occurs (but no earlier than one year preceding the month of the filing of an application for benefits under this section); and

(2) shall end, in the case of an individual who receives a kidney transplant, with the thirty-sixth month after the month in which such individual receives such transplant or, in the case of an individual who has not received a kidney transplant and no longer requires a regular course of dialysis, with the twelfth month after the month in which such course of dialysis is terminated.

(c) Notwithstanding the provisions of subsection (b)—

(1) in the case of any individual who participates in a self-care dialysis training program prior to the third month after the month in which such individual initiates a regular course of

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[489] P.L. 75-162 [as amended by P.L. 93-445].

[490] P.L. 75-162 [as amended by P.L. 93-445].

renal dialysis in a renal dialysis facility or provider of services meeting the requirements of section 1881(b), entitlement to benefits under part A and eligibility to enroll under part B of title XVIII shall begin with the month in which such regular course of renal dialysis is initiated;

(2) in any case in which a kidney transplant fails (whether during or after the thirty-six-month period specified in subsection (b)(2)) and as a result the individual who received such transplant initiates or resumes a regular course of renal dialysis, entitlement to benefits under part A and eligibility to enroll under part B of title XVIII shall begin with the month in which such course is initiated or resumed; and

(3) in any case in which a regular course of renal dialysis is resumed subsequent to the termination of an earlier course, entitlement to benefits under part A and eligibility to enroll under part B of title XVIII shall begin with the month in which such regular course of renal dialysis is resumed.

TRANSITIONAL INSURED STATUS

SEC. 227. [42 U.S.C. 427] (a) In the case of any individual who attains the age of 72 before 1969 but who does not meet the requirements of section 214(a), the 6 quarters of coverage referred to in paragraph (1) of section 214(a) shall, instead, be 3 quarters of coverage for purposes of determining entitlement of such individual to benefits under section 202(a), and of the spouse to benefits under section 202(b) or section 202(c), but, in the case of such spouse, only if he or she attains the age of 72 before 1969 and only with respect to spouse's insurance benefits under section 202(b) or section 202(c) for and after the month in which he or she attains such age. For each month before the month in which any such individual meets the requirements of section 214(a), the amount of the old-age insurance benefit shall, notwithstanding the provisions of section 202(a), be the larger of $64.40 or the amount most recently established in lieu thereof under section 215(i) and the amount of the spouse's insurance benefit of the spouse shall, notwithstanding the provisions of section 202(b) or section 202(c), be the larger of $32.20 or the amount most recently established in lieu thereof under section 215(i)[491].

(b) In the case of any individual who has died, who does not meet the requirements of section 214(a), and whose surviving spouse attains age 72 before 1969, the 6 quarters of coverage referred to in paragraph (3) of section 214(a) and in paragraph (1) thereof shall, for purposes of determining the entitlement to surviving spouse's insurance benefits under section 202(e) or section 202(f), instead be—

(1) 3 quarters of coverage if such surviving spouse attains the age of 72 in or before 1966,

(2) 4 quarters of coverage if such surviving spouse attains the age of 72 in 1967, or

(3) 5 quarters of coverage if such surviving spouse attains the age of 72 in 1968.

The amount of the surviving spouse's insurance benefit for each month shall, notwithstanding the provisions of section 202(e) or section 202(f) (and section 202(m)), be the larger of $64.40 or the amount most recently established in lieu thereof under section 215(i)[492].

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[491] For benefits beginning December 1989: $159.00 and $79.60 (54 FR 45802; October 31, 1989) and for benefits beginning December 1990: $167.50 and $83.80 (55 FR 45856; October 31, 1990).

(c) In the case of any individual who becomes, or upon filing application therefor would become, entitled to benefits under section 202(a) by reason of the application of subsection (a) of this section, who dies, and whose surviving spouse attains the age of 72 before 1969, such deceased individual shall be deemed to meet the requirements of subsection (b) of this section for purposes of determining entitlement of such surviving spouse to surviving spouse's insurance benefits under section 202(e) or section 202(f).

BENEFITS AT AGE 72 FOR CERTAIN UNINSURED INDIVIDUALS[493]

Eligibility

SEC. 228. [42 U.S.C. 428] (a) Every individual who—

(1) has attained the age of 72,

(2)(A) attained such age before 1968, or (B) (i) attained such age after 1967 and before 1972, and[494] (ii)[495] has not less than 3 quarters of coverage, whenever acquired, for each calendar year elapsing after 1966 and before the year in which he or she attained such age,

(3) is a resident of the United States (as defined in subsection (e)), and is (A) a citizen of the United States or (B) an alien lawfully admitted for permanent residence who has resided in the United States (as defined in section 210(i)) continuously during the 5 years immediately preceding the month in which he or she files application under this section, and

(4) has filed application for benefits under this section,

shall (subject to the limitations in this section) be entitled to a benefit under this section for each month beginning with the first month after September 1966 in which he or she becomes so entitled to such benefits and ending with the month preceding the month in which he or she dies. No application under this section which is filed by an individual more than 3 months before the first month in which he or she meets the requirements of paragraphs (1), (2), and (3) shall be accepted as an application for purposes of this section.

Benefit Amount[496]

(b) The benefit amount to which an individual is entitled under this section for any month shall be the larger of $64.40 or the amount most recently established in lieu thereof under section 215(i).

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[492] See §227(a) with respect to rate increases.

[493] In P.L. 94-241, §1, effective March 24, 1976, Congress approved the "Covenant To Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States of America". Section 502 of that Covenant [set out in P.L. 94-241, §1], provides that §228 of the Social Security Act is applicable to the Northern Mariana Islands, except as otherwise provided. Proclamation 4534 of The President, dated October 24, 1977, provides that §502 is effective at 11 A.M., January 9, 1978, Northern Mariana Islands local time.

See Vol. II, P.L. 98-21, §305(e), with respect to changes in payment amounts under this section.

[494] P.L. 101-508, §5114(a), added clause (i), applicable to benefits payable on the basis of applications filed after November 5, 1990.

[495] P.L. 101-508, §5114(a), inserted "(ii)".

[496] The individual benefit amount beginning with benefits for December 1989 is $159.00 (54 FR 45802; October 31, 1989).

Reduction for Governmental Pension System Benefits

(c)(1) The benefit amount of any individual under this section for any month shall be reduced (but not below zero) by the amount of any periodic benefit under a governmental pension system for which he or she is eligible for such month.

(2) In the case of a husband and wife only one of whom is entitled to benefits under this section for any month, the benefit amount, after any reduction under paragraph (1), shall be further reduced (but not below zero) by the excess (if any) of (A) the total amount of any periodic benefits under governmental pension systems for which the spouse who is not entitled to benefits under this section is eligible for such month, over (B) the benefit amount as determined without regard to this subsection.

(3) In the case of a husband or wife both of whom are entitled to benefits under this section for any month, the benefit amount of each spouse, after any reduction under paragraph (1), shall be further reduced (but not below zero) by the excess (if any) of (A) the total amount of any periodic benefits under governmental pension systems for which the other spouse is eligible for such month, over (B) the benefit amount of such other spouse as determined without regard to this subsection.

(4) For purposes of this subsection, in determining whether an individual is eligible for periodic benefits under a governmental pension system—

(A) such individual shall be deemed to have filed application for such benefits,

(B) to the extent that entitlement depends on an application by such individual's spouse, such spouse shall be deemed to have filed application, and

(C) to the extent that entitlement depends on such individual or his or her spouse having retired, such individual and his or her spouse shall be deemed to have retired before the month for which the determination of eligibility is being made.

(5) For purposes of this subsection, if any periodic benefit is payable on any basis other than a calendar month, the Secretary shall allocate the amount of such benefit to the appropriate calendar months.

(6) If, under the foregoing provisions of this section, the amount payable for any month would be less than $1, such amount shall be reduced to zero. In the case of a husband and wife both of whom are entitled to benefits under this section for the month, the preceding sentence shall be applied with respect to the aggregate amount so payable for such month.

(7) If any benefit amount computed under the foregoing provisions of this section is not a multiple of $0.10, it shall be raised to the next higher multiple of $0.10.

(8) Under regulations prescribed by the Secretary, benefit payments under this section to an individual (or aggregate benefit payments under this section in the case of a husband and wife) of less than $5 may be accumulated until they equal or exceed $5.

Suspension for Months in Which Cash Payments Are Made Under Public Assistance

(d) The benefit to which any individual is entitled under this section for any month shall not be paid for such month if—

(1) such individual receives aid or assistance in the form of money payments in such month under a State plan approved under title I, X, XIV, or XVI, or part A of title IV, or

(2) such individual's husband or wife receives such aid or assistance in such month, and under the State plan the needs of such individual were taken into account in determining eligibility for (or amount of) such aid or assistance,

unless the State agency administering or supervising the administration of such plan notifies the Secretary, at such time and in such manner as may be prescribed in accordance with regulations of the Secretary, that such payments to such individual (or such individual's husband or wife) under such plan are being terminated with the payment or payments made in such month and such individual is not an individual with respect to whom supplemental security income benefits are payable pursuant to title XVI or section 211 of Public Law 93-66 for the following month, nor shall such benefit be paid for such month if such individual is an individual with respect to whom supplemental security income benefits are payable pursuant to title XVI or section 211 of Public Law 93-66 for such month, unless the Secretary determines that such benefits are not payable with respect to such individual for the month following such month.

Suspension Where Individual Is Residing Outside the United States

(e) The benefit to which any individual is entitled under this section for any month shall not be paid if, during such month, such individual is not a resident of the United States. For purposes of this subsection, the term "United States" means the 50 States and the District of Columbia.

Treatment as Monthly Insurance Benefits

(f) For purposes of subsections (t) and (u) of section 202, and of section 1840, a monthly benefit under this section shall be treated as a monthly insurance benefit payable under section 202.

Annual Reimbursement of Federal Old-Age and Survivors Insurance Trust Fund

(g) There are authorized to be appropriated to the Federal Old-Age and Survivors Insurance Trust Fund for the fiscal year ending June 30, 1969, and for each fiscal year thereafter, such sums as the Secretary deems necessary on account of—

(1) payments made under this section during the second preceding fiscal year and all fiscal years prior thereto to individuals who, as of the beginning of the calendar year in which falls the month for which payment was made, had less than 3 quarters of coverage,

(2) the additional administrative expenses resulting from the payments described in paragraph (1), and

(3) any loss in interest to such Trust Fund resulting from such payments and expenses,

in order to place such Trust Fund in the same position at the end of such fiscal year as it would have been in if such payments had not been made.

Definitions

(h) For purposes of this section—

(1) The term "quarter of coverage" includes a quarter of coverage as defined in section 5(l) of the Railroad Retirement Act of 1937[497].

(2) The term "governmental pension system" means the insurance system established by this title or any other system or fund established by the United States, a State, any political subdivision of a State, or any wholly owned instrumentality of any one or more of the foregoing which provides for payment of (A) pensions, (B) retirement or retired pay, or (C) annuities or similar amounts payable on account of personal services performed by any individual (not including any payment under any workmen's compensation law or any payment by the Veterans' Administration as compensation for service-connected disability or death).

(3) The term "periodic benefit" includes a benefit payable in a lump sum if it is a commutation of, or a substitute for, periodic payments.

(4) The determination of whether an individual is a husband or wife for any month shall be made under subsection (h) of section 216 without regard to subsections (b) and (f) of section 216.

BENEFITS IN CASE OF MEMBERS OF THE UNIFORMED SERVICES

SEC. 229. [42 U.S.C. 429] (a) For purposes of determining entitlement to and the amount of any monthly benefit for any month after December 1972, or entitlement to and the amount of any lump-sum death payment in case of a death after such month, payable under this title on the basis of the wages and self-employment income of any individual, and for purposes of section 216(i)(3), such individual, if he was paid wages for service as a member of a uniformed service (as defined in section 210(m)) which was included in the term "employment" as defined in section 210(a) as a result of the provisions of section 210(l)(1)(A), shall be deemed to have been paid—

(1) in each calendar quarter occurring after 1956 and before 1978 in which he was paid such wages, additional wages of $300, and

(2) in each calendar year occurring after 1977 in which he was paid such wages, additional wages of $100 for each $300 of such wages, up to a maximum of $1,200 of additional wages for any calendar year.[498]

(b) There are authorized to be appropriated to each of the Trust Funds, consisting of the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and the Federal Hospital Insurance Trust Fund, for transfer on July 1 of each calendar year to such Trust Fund from amounts in the general fund in the Treasury not otherwise appropriated, an amount equal to the total of the additional amounts which would be appropriated to such Trust Fund for the fiscal year ending September 30 of such calendar year under section 201 or 1817 of this Act if the amounts of the additional wages deemed to have been paid for such calendar year by reason of subsection (a) constituted remuneration for employment (as defined in section 3121(b) of the Internal Revenue Code of 1954[499]) for purposes of the taxes imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954[500]. Amounts authorized to be appropriated under this subsection for transfer on July 1 of each calendar year shall be determined on the basis of estimates of the Secretary of the wages deemed to be paid for such calendar year under subsection (a); and proper adjustments shall be made in amounts authorized to be appropriated for subsequent transfer to the extent prior estimates were in excess of or were less than such wages so deemed to be paid. Additional adjustments may be made in the amounts so authorized to be appropriated to the extent that the amounts transferred in accordance with clauses (i) and (ii) of section 151(b)(3)(B) of the Social Security Amendments of 1983[501] with respect to wages deemed to have been paid in 1983 were in excess of or were less than the amount which the Secretary, on the basis of appropriate data, determines should have been so transferred.

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[497] P.L. 75-162. P.L. 93-445, §101, amended the "Railroad Retirement Act of 1937" in its entirety, effective January 1, 1975. See Vol. II, P.L. 75-162, §2, instead.

[498] See Vol. II, 38 U.S.C. 3103A.

ADJUSTMENT OF THE CONTRIBUTION AND BENEFIT BASE

SEC. 230. [42 U.S.C. 430] (a) Whenever the Secretary pursuant to section 215(i) increases benefits effective with the December following a cost-of-living computation quarter, he shall also determine and publish in the Federal Register on or before November 1 of the calendar year in which such quarter occurs the contribution and benefit base determined under subsection (b) or (c) which shall be effective with respect to remuneration paid after the calendar year in which such quarter occurs and taxable years beginning after such year.

(b) The amount of such contribution and benefit base shall (subject to subsection (c)) be the amount of the contribution and benefit base in effect in the year in which the determination is made or, if larger, the product of—

(1) the contribution and benefit base which is in effect with respect to remuneration paid in (and taxable years beginning in) the calendar year in which the determination under subsection (a) is made, and

(2) the ratio of (A) the deemed average total wages (as defined in section 209(k)(1))[502] for the calendar year before the calendar year in which the determination under subsection (a) is made to (B) the deemed average total wages (as so defined)[503] for the

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[499] See P.L. 83-591, §3121, (this volume).

[500] See P.L. 83-591, §3101, (this volume).

[501] P.L. 98-21.

[502] P.L. 101-239, §10208(b)(1)(A), struck out "the average of the total wages (as defined in regulations of the Secretary and computed without regard to the limitations specified in section 209(a)(1)[*]) reported to the Secretary of the Treasury or his delegate" and substituted "the deemed average total wages (as defined in section 209(k)(1))", applicable with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

[*] P.L. 101-239, §10208(d)(2)(A)(i), struck out "209(a)" and substituted "209(a)(1)", effective December 19, 1989.

[503] P.L. 101-239, §10208(b)(1)(B), struck out "the average of the total wages (as so defined and computed) reported to the Secretary of the Treasury or his delegate" and substituted "the deemed

calendar year before the most recent calendar year in which an increase in the contribution and benefit base was enacted or a determination resulting in such an increase was made under subsection (a),

with such product, if not a multiple of $300, being rounded to the next higher multiple of $300 where such product is a multiple of $150 but not of $300 and to the nearest multiple of $300 in any other case.[504]

(c) For purposes of this section, and for purposes of determining wages and self-employment income under sections 209, 211, 213, and 215 of this Act and sections 1402, 3121, 3122, 3125, 6413, and 6654 of the Internal Revenue Code of 1954[505], (1) the "contribution and benefit base" with respect to remuneration paid in (and taxable years beginning in) any calendar year after 1973 and prior to the calendar year with the June of which the first increase in benefits pursuant to section 215(i) of this Act becomes effective shall be $13,200 or (if applicable) such other amount as may be specified in a law enacted subsequent to the law which added this section, and (2) the "contribution and benefit base" with respect to remuneration paid (and taxable years beginning)—

(A) in 1978 shall be $17,700,
(B) in 1979 shall be $22,900,[506]
(C) in 1980 shall be $25,900, and
(D) in 1981 shall be $29,700.[507]

For purposes of determining under subsection (b) the "contribution and benefit base" with respect to remuneration paid (and taxable years beginning) in 1982 and subsequent years, the dollar amounts specified in clause (2) of the preceding sentence shall be considered to have resulted from the application of such subsection (b) and to be the amount determined (with respect to the years involved) under that subsection.

(d) Notwithstanding any other provision of law, the contribution and benefit base determined under this section for any calendar year after 1976 for purposes of section 4022(b)(3)(B) of Public Law 93-406, with respect to any plan, shall be the contribution and benefit base that would have been determined for such year if this section as in effect immediately prior to the enactment of the Social Security Amendments of 1977[508] had remained in effect without change (except that, for purposes of subsection (b)(2)(A) of such section 230 as so in effect, the reference therein to the average of the wages of all employees as reported to the Secretary of the Treasury for any calendar year shall be deemed a reference to the deemed average total wage (within the meaning of section 209(k)(1)) for such calendar year).[509]

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average total wages (as so defined)", applicable with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

Executed as if §10208(b)(1)(B) amended §230(b)(2)(B) instead of §230(b)(2)(A).

[504] See Vol. II, P.L. 101-239, §10208(c)(2)-(4), with respect to information on the contribution and benefit base.

[505] See P.L. 83-591, §1402, (this volume).

[506] In figuring special minimum benefits under the pre-1977 law for workers with many years of low earnings, for certain railroad retirement program purposes and for ERISA, the contribution and benefit base is: $38,100 for 1990 (54 FR 53751; 12-29-89).

[507] In 1990 shall be $51,300 (54 FR 53751; December 29, 1989).

[508] December 20, 1977 [P.L. 95-216, 91 Stat. 1509].

[509] P.L. 101-239, §10208(b)(5), struck out the period and inserted "(except that, for purposes of subsection (b)(2)(A) of such section 230 as so in effect, the reference therein to the average of the wages of all employees as reported to the Secretary of the Treasury for any calendar year shall be

BENEFITS IN CASE OF CERTAIN INDIVIDUALS INTERNED DURING WORLD WAR II

SEC. 231. [42 U.S.C. 431] (a) For the purposes of this section the term "internee" means an individual who was interned during any period of time from December 7, 1941, through December 31, 1946, at a place within the United States operated by the Government of the United States for the internment of United States citizens of Japanese ancestry.

(b)(1) For purposes of determining entitlement to and the amount of any monthly benefit for any month after December 1972, or entitlement to and the amount of any lump-sum death payment in the case of a death after such month, payable under this title on the basis of the wages and self-employment income of any individual, and for purposes of section 216(i)(3), such individual shall be deemed to have been paid during any period after he attained age 18 and for which he was an internee, wages (in addition to any wages actually paid to him) at a weekly rate of basic pay during such period as follows—

(A) in the case such individual was not employed prior to the beginning of such period, 40 multiplied by the minimum hourly rate or rates in effect at any such time under section 206(a)(1) of title 29, United States Code, for each full week during such period; and

(B) in the case such individual who was employed prior to the beginning of such period, 40 multiplied by the greater of (i) the highest hourly rate received during any such employment, or (ii) the minimum hourly rate or rates in effect at any such time under section 206(a)(1) of title 29, United States Code, for each full week during such period.

(2) This subsection shall not be applicable in the case of any monthly benefit or lump-sum death payment if—

(A) a larger such benefit or payment, as the case may be, would be payable without its application; or

(B) a benefit (other than a benefit payable in a lump-sum unless it is a commutation of, or a substitute for, periodic payments) which is based, in whole or in part, upon internment during any period from December 7, 1941, through December 31, 1946, at a place within the United States operated by the Government of the United States for the internment of United States citizens of Japanese ancestry, is determined by any agency or wholly owned instrumentality of the United States to be payable by it under any other law of the United States or under a system established by such agency or instrumentality.

The provisions of clause (B) shall not apply in the case of any monthly benefit or lump-sum death payment under this title if its application would reduce by $0.50 or less the primary insurance amount (as computed under section 215 prior to any recomputation thereof pursuant to subsection (f) of such section) of the individual on whose wages and self-employment income such benefit or payment is based. The provisions of clause (B) shall also not apply for purposes of section 216(i)(3).

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deemed a reference to the deemed average total wage (within the meaning of section 209(k)(1)) for such calendar year).", applicable with respect to the computation of average total wage amounts (under the amended provisions) for calendar years after 1990.

(3) Upon application for benefits, a recalculation of benefits (by reason of this section), or a lump-sum death payment on the basis of the wages and self-employment income of any individual who was an internee, the Secretary of Health and Human Services shall accept the certification of the Secretary of Defense or his designee concerning any period of time for which an internee is to receive credit under paragraph (1) and shall make a decision without regard to clause (B) of paragraph (2) of this subsection unless he has been notified by some other agency or instrumentality of the United States that, on the basis of the period for which such individual was an internee, a benefit described in clause (B) of paragraph (2) has been determined by such agency or instrumentality to be payable by it. If the Secretary of Health and Human Services has not been so notified, he shall then ascertain whether some other agency or wholly owned instrumentality of the United States has decided that a benefit described in clause (B) of paragraph (2) is payable by it. If any such agency or instrumentality has decided, or thereafter decides, that such a benefit is payable by it, it shall so notify the Secretary of Health and Human Services, and the Secretary shall certify no further benefits for payment or shall recompute the amount of any further benefits payable, as may be required by this section.

(4) Any agency or wholly owned instrumentality of the United States which is authorized by any law of the United States to pay benefits, or has a system of benefits which are based, in whole or in part, on any period for which any individual was an internee shall, at the request of the Secretary of Health and Human Services, certify to him, with respect to any individual who was an internee, such information as the Secretary deems necessary to carry out his functions under paragraph (3) of this subsection.

(c) There are authorized to be appropriated to the Trust Funds and the Federal Hospital Insurance Trust Fund for the fiscal year ending June 30, 1978, such sums as the Secretary determines would place the Trust Funds and the Federal Hospital Insurance Trust Fund in the position in which they would have been if the preceding provisions of this section had not been enacted.

PROCESSING OF TAX DATA[510]

SEC. 232. [42 U.S.C. 432] The Secretary of the Treasury shall make available information returns filed pursuant to part III of subchapter A of chapter 61 of subtitle F of the Internal Revenue Code of 1954[511], to the Secretary for the purposes of this title and title XI. The Secretary and the Secretary of the Treasury are authorized to enter into an agreement for the processing by the Secretary of information contained in returns filed pursuant to part III of subchapter A of chapter 61 of subtitle F of the Internal Revenue Code of 1954. Notwithstanding the provisions of section 6103(a) of the Internal Revenue Code of 1954, the Secretary of the Treasury shall make available to the Secretary such documents as may be agreed upon as being necessary for purposes of such processing. The

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[510] See Vol. II, P.L. 88-525, §11(e)(19), with respect to requesting and exchanging information for purposes of verifying income and eligibility for food stamps.

See Vol. II, P.L. 83-591, §6103(l) with respect to disclosure of returns and return information by the Secretary of the Treasury to the Social Security Administration, and §7213(a)(1) with respect to the penalty for unauthorized disclosure of that tax return information.

[511] P.L. 83-591.

Secretary shall process any withholding tax statements or other documents made available to him by the Secretary of the Treasury pursuant to this section. Any agreement made pursuant to this section shall remain in full force and effect until modified or otherwise changed by mutual agreement of the Secretary and the Secretary of the Treasury.

INTERNATIONAL AGREEMENTS

Purpose of Agreement

SEC. 233. [42 U.S.C. 433] (a) The President is authorized (subject to the succeeding provisions of this section) to enter into agreements establishing totalization arrangements between the social security system established by this title and the social security system of any foreign country, for the purposes of establishing entitlement to and the amount of old-age, survivors, disability, or derivative benefits based on a combination of an individual's periods of coverage under the social security system established by this title and the social security system of such foreign country.

Definitions

(b) For the purposes of this section—

(1) the term "social security system" means, with respect to a foreign country, a social insurance or pension system which is of general application in the country and under which periodic benefits, or the actuarial equivalent thereof, are paid on account of old age, death, or disability; and

(2) the term "period of coverage" means a period of payment of contributions or a period of earnings based on wages for employment or on self-employment income, or any similar period recognized as equivalent thereto under this title or under the social security system of a country which is a party to an agreement entered into under this section.

Crediting Periods of Coverage; Conditions of Payment of Benefits

(c)(1) Any agreement establishing a totalization arrangement pursuant to this section shall provide—

(A) that in the case of an individual who has at least 6 quarters of coverage as defined in section 213 of this Act and periods of coverage under the social security system of a foreign country which is a party to such agreement, periods of coverage of such individual under such social security system of such foreign country may be combined with periods of coverage under this title and otherwise considered for the purposes of establishing entitlement to and the amount of old-age, survivors, and disability insurance benefits under this title;

(B)(i) that employment or self-employment, or any service which is recognized as equivalent to employment or self-employment under this title or the social security system of a foreign country which is a party to such agreement, shall, on or after the effective date of such agreement, result in a period of coverage under the system established under this title or under the system established under the laws of such foreign country, but not under both, and (ii) the methods and conditions for determining under which system employment, self-employment, or other service shall result in a period of coverage; and

(C) that where an individual's periods of coverage are combined, the benefit amount payable under this title shall be based on the proportion of such individual's periods of coverage which was completed under this title.

(2) Any such agreement may provide that an individual who is entitled to cash benefits under this title shall, notwithstanding the provisions of section 202(t), receive such benefits while he resides in a foreign country which is a party to such agreement.

(3) Section 226 shall not apply in the case of any individual to whom it would not be applicable but for this section or any agreement or regulation under this section.

(4) Any such agreement may contain other provisions which are not inconsistent with the other provisions of this title and which the President deems appropriate to carry out the purposes of this section.

Regulations

(d) The Secretary shall make rules and regulations and establish procedures which are reasonable and necessary to implement and administer any agreement which has been entered into in accordance with this section.

Reports to Congress; Effective Date of Agreements

(e)(1) Any agreement to establish a totalization arrangement entered into pursuant to this section shall be transmitted by the President to the Congress together with a report on the estimated number of individuals who will be affected by the agreement and the effect of the agreement on the estimated income and expenditures of the programs established by this Act.

(2) Such an agreement shall become effective on any date, provided in the agreement, which occurs after the expiration of the period (following the date on which the agreement is transmitted in accordance with paragraph (1)) during which at least one House of the Congress has been in session on each of 60 days; except that such agreement shall not become effective if, during such period, either House of the Congress adopts a resolution of disapproval of the agreement.

TITLE III—GRANTS TO STATES FOR UNEMPLOYMENT COMPENSATION ADMINISTRATION[1]

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APPROPRIATIONS

SEC. 301. [42 U.S.C. 501] The amounts made available pursuant to section 901(c)(1)(A) for the purpose of assisting the States in the administration of their unemployment compensation laws shall be used as hereinafter provided.

PAYMENTS TO STATES

SEC. 302. [42 U.S.C. 502] (a) The Secretary of Labor shall from time to time certify to the Secretary of the Treasury for payment to each State which has an unemployment compensation law approved by the Secretary of Labor under the Federal Unemployment Tax Act[3], such amounts as the Secretary of Labor determines to be necessary for the proper and efficient administration of such law during the fiscal year for which such payment is to be made, including 100 percent of so much of the reasonable expenditures of the State as are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1137(d). The Secretary of Labor's determination shall be based on (1) the population of the State; (2) an estimate of the number of persons covered by the State law and of the cost of proper and efficient administration of such law; and (3) such other factors as the Secretary of Labor finds relevant. The Secretary of Labor shall not certify for payment under this section in any fiscal year a total amount in excess of the amount appropriated therefor for such fiscal year.

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[1] The President's Reorganization Plan No. 2 of 1949, §1 (14 FR 5225, 63 Stat. 1065), transferred the Bureau of Employment Security, including the United States Employment Service, from the Federal Security Agency to the Department of Labor, effective August 20, 1949.

Title III of the Social Security Act is administered by the Department of Labor.

Title III appears in the United States Code as §§501-504 of subchapter III, chapter 7, Title 42.

Regulations of the Secretary of Labor relating to Title III are contained in chapter V, Title 20, and subtitle A, Title 29, Code of Federal Regulations. Regulations of the Secretary of Health and Human Services (formerly Secretary of Health, Education, and Welfare) relating to Title III are contained in subtitle A, Title 45, Code of Federal Regulations.

See Vol. II, P.L. 95-521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 97-248, §604(c), with respect to an appropriation of funds to assist States in meeting administrative costs.

See Vol. II, P.L. 100-628, §904(c)(2) and (3), with respect to access to State employment records.

[2] This table of contents does not appear in the law.

[3] The "Federal Unemployment Tax Act" is in §§3301-3311 of P.L. 83-591 (this volume).

(b) Out of the sums appropriated therefor, the Secretary of the Treasury shall, upon receiving a certification under subsection (a), pay, through the Fiscal Service of the Department of the Treasury and prior to audit or settlement by the General Accounting Office, to the State agency charged with the administration of such law the amount so certified.

PROVISIONS OF STATE LAWS

SEC. 303. [42 U.S.C. 503] (a) The Secretary of Labor shall make no certification for payment to any State unless he finds that the law of such State, approved by the Secretary of Labor under the Federal Unemployment Tax Act[4], includes provision for—

(1) Such methods of administration (including after January 1, 1940, methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary of Labor shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary of Labor to be reasonably calculated to insure full payment of unemployment compensation when due[5]; and

(2) Payment of unemployment compensation solely through public employment offices or such other agencies as the Secretary of Labor may approve; and

(3) Opportunity for a fair hearing, before an impartial tribunal, for all individuals whose claims for unemployment compensation are denied; and

(4) The payment of all money received in the unemployment fund of such State (except for refunds of sums erroneously paid into such fund and except for refunds paid in accordance with the provisions of section 3305(b) of the Federal Unemployment Tax Act[6]), immediately upon such receipt, to the Secretary of the Treasury to the credit of the unemployment trust fund[7] established by section 904; and

(5) Expenditure of all money withdrawn from an unemployment fund of such State, in the payment of unemployment compensation, exclusive of expenses of administration, and for refunds of sums erroneously paid into such fund and refunds paid in accordance with the provisions of section 3305(b) of the Federal Unemployment Tax Act: *Provided*, That an amount equal to the amount of employee payments into the unemployment fund of a State may be used in the payment of cash benefits to individuals with respect to their disability, exclusive of expenses of administration: *Provided further*, That the amounts specified by section 903(c)(2) may, subject to the conditions prescribed in such section, be used for expenses incurred by

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[4] See P.L. 83-591, §§3301-3311 (this volume).

[5] P.L. 91-648, §208(a)(2)(B), transferred to the U.S. Civil Service Commission, effective March 6, 1971, all functions, powers, and duties of the Secretary of Labor under paragraph (1).

[6] See P.L. 83-591, §3305(b) (this volume).

[7] As in original. Probably should be "Unemployment Trust Fund".

the State for administration of its unemployment compensation law and public employment offices: *Provided further*, That nothing in this paragraph shall be construed to prohibit deducting an amount from unemployment compensation otherwise payable to an individual and using the amount so deducted to pay for health insurance if the individual elected to have such deduction made and such deduction was made under a program approved by the Secretary of Labor: *Provided further*, That amounts may be deducted from unemployment benefits and used to repay overpayments as provided in subsection (g); and

(6) The making of such reports, in such form and containing such information, as the Secretary of Labor may from time to time require, and compliance with such provisions as the Secretary of Labor may from time to time find necessary to assure the correctness and verification of such reports; and

(7) Making available upon request to any agency of the United States charged with the administration of public works or assistance through public employment, the name, address, ordinary occupation and employment status of each recipient of unemployment compensation, and a statement of such recipient's rights to further compensation under such law; and

(8) Effective July 1, 1941, the expenditure of all moneys received pursuant to section 302 of this title solely for the purposes and in the amounts found necessary by the Secretary of Labor for the proper and efficient administration of such State law; and

(9) Effective July 1, 1941, the replacement, within a reasonable time, of any moneys received pursuant to section 302 of this title, which, because of any action or contingency, have been lost or have been expended for purposes other than, or in amounts in excess of, those found necessary by the Secretary of Labor for the proper administration of such State law.

(b) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that in the administration of the law there is—

(1) a denial, in a substantial number of cases, of unemployment compensation to individuals entitled thereto under such law; or

(2) a failure to comply substantially with any provision specified in subsection (a);

the Secretary of Labor shall notify such State agency that further payments will not be made to the State until the Secretary of Labor is satisfied that there is no longer any such denial or failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State: *Provided*, That there shall be no finding under clause (1) until the question of entitlement shall have been decided by the highest judicial authority given jurisdiction under such State law: *Provided further*, That any costs may be paid with respect to any claimant by a State and included as costs of administration of its law.

(c) The Secretary of Labor shall make no certification for payment to any State if he finds, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law—

(1) that such State does not make its records available to the Railroad Retirement Board, and furnish to the Railroad Retirement Board at the expense of the Railroad Retirement Board such copies thereof as the Railroad Retirement Board deems necessary for its purposes;

(2) that such State is failing to afford reasonable cooperation with every agency of the United States charged with the administration of any unemployment insurance law; or

(3) that any interest required to be paid on advances under title XII of this Act has not been paid by the date on which such interest is required to be paid or has been paid directly or indirectly (by an equivalent reduction in State unemployment taxes or otherwise) by such State from amounts in such State's unemployment fund, until such interest is properly paid.

(d)(1) The State agency charged with the administration of the State law—

(A) shall disclose, upon request and on a reimbursable basis, to officers and employees of the Department of Agriculture and to officers or employees of any State food stamp agency any of the following information contained in the records of such State agency—

(i) wage information,

(ii) whether an individual is receiving, has received, or has made application for, unemployment compensation, and the amount of any such compensation being received (or to be received) by such individual,

(iii) the current (or most recent) home address of such individual, and

(iv) whether an individual has refused an offer of employment and, if so, a description of the employment so offered and the terms, conditions, and rate of pay therefor, and

(B) shall establish such safeguards as are necessary (as determined by the Secretary of Labor in regulations) to insure that information disclosed under subparagraph (A) is used only for purposes of determining an individual's eligibility for benefits, or the amount of benefits, under the food stamp program established under the Food Stamp Act of 1977[8].

(2)(A) For purposes of this paragraph, the term "unemployment compensation" means any unemployment compensation payable under the State law (including amounts payable pursuant to an agreement under a Federal unemployment compensation law).

(B) The State agency charged with the administration of the State law—

(i) may require each new applicant for unemployment compensation to disclose whether the applicant owes an uncollected overissuance (as defined in section 13(c)(1) of the Food Stamp Act of 1977) of food stamp coupons,

(ii) may notify the State food stamp agency to which the uncollected overissuance is owed that the applicant has been determined to be eligible for unemployment compensation if the applicant discloses under clause (i) that the applicant owes an uncollected overissuance and the applicant is determined to be so eligible,

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[8] P.L. 88-525.

(iii) may deduct and withhold from any unemployment compensation otherwise payable to an individual—

(I) the amount specified by the individual to the State agency to be deducted and withheld under this clause,

(II) the amount (if any) determined pursuant to an agreement submitted to the State food stamp agency under section 13(c)(3)(A) of the Food Stamp Act of 1977, or

(III) any amount otherwise required to be deducted and withheld from the unemployment compensation pursuant to section 13(c)(3)(B) of such Act, and

(iv) shall pay any amount deducted and withheld under clause (iii) to the appropriate State food stamp agency.

(C) Any amount deducted and withheld under subparagraph (B)(iii) shall for all purposes be treated as if it were paid to the individual as unemployment compensation and paid by the individual to the State food stamp agency to which the uncollected overissuance is owed as repayment of the individual's uncollected overissuance.

(D) A State food stamp agency to which an uncollected overissuance is owed shall reimburse the State agency charged with the administration of the State unemployment compensation law for the administrative costs incurred by the State agency under this paragraph that are attributable to repayment of uncollected overissuance to the State food stamp agency to which the uncollected overissuance is owed.

(3) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirements of paragraph (1), the Secretary of Labor shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, he shall make no further certification to the Secretary of the Treasury with respect to such State.

(4) For purposes of this subsection, the term "State food stamp agency" means any agency described in section 3(n)(1) of the Food Stamp Act of 1977 which administers the food stamp program established under such Act.[9]

(e)(1) The State agency charged with the administration of the State law—

(A) shall disclose, upon request and on a reimbursable basis, directly to officers or employees of any State or local child support enforcement agency any wage information contained in the records of such State agency, and

(B) shall establish such safeguards as are necessary (as determined by the Secretary of Labor in regulations) to insure that information disclosed under subparagraph (A) is used only for purposes of establishing and collecting child support obligations from, and locating, individuals owing such obligations.

For purposes of this subsection, the term "child support obligations" only includes obligations which are being enforced pursuant to a plan described in section 454 of this Act which has been approved by the Secretary of Health and Human Services under part D of title IV of this Act.

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[9] See Vol. II, P.L. 88-525, §11(e)(19), with respect to requesting and exchanging information for verifying income and eligibility for food stamps.

(2)(A) The State agency charged with the administration of the State law—

(i) shall require each new applicant for unemployment compensation to disclose whether or not such applicant owes child support obligations (as defined in the last sentence of paragraph (1)),

(ii) shall notify the State or local child support enforcement agency enforcing such obligations, if any applicant discloses under clause (i) that he owes child support obligations and he is determined to be eligible for unemployment compensation, that such applicant has been so determined to be eligible,

(iii) shall deduct and withhold from any unemployment compensation otherwise payable to an individual—

(I) the amount specified by the individual to the State agency to be deducted and withheld under this clause,

(II) the amount (if any) determined pursuant to an agreement submitted to the State agency under section 454(19)(B)(i) of this Act, or

(III) any amount otherwise required to be so deducted and withheld from such unemployment compensation through legal process (as defined in section 462(e)), and

(iv) shall pay any amount deducted and withheld under clause (iii) to the appropriate State or local child support enforcement agency.

Any amount deducted and withheld under clause (iii) shall for all purposes be treated as if it were paid to the individual as unemployment compensation and paid by such individual to the State or local child support enforcement agency in satisfaction of his child support obligations.

(B) For purposes of this paragraph, the term "unemployment compensation" means any compensation payable under the State law (including amounts payable pursuant to agreements under any Federal unemployment compensation law).

(C) Each State or local child support enforcement agency shall reimburse the State agency charged with the administration of the State unemployment compensation law for the administrative costs incurred by such State agency under this paragraph which are attributable to child support obligations being enforced by the State or local child support enforcement agency.

(3) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirements of paragraph (1) or (2), the Secretary of Labor shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, he shall make no further certification to the Secretary of the Treasury with respect to such State.[10]

(4) For purposes of this subsection, the term "State or local child support enforcement agency" means any agency of a State or political subdivision thereof operating pursuant to a plan described in the last sentence of paragraph (1).

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[10] See Vol. II, P.L. 96-499, §1025, with respect to withholding certification of State unemployment laws.

(f) The State agency charged with the administration of the State law shall provide that information shall be requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act.

(g)(1) A State may deduct from unemployment benefits otherwise payable to an individual an amount equal to any overpayment made to such individual under an unemployment benefit program of the United States or of any other State, and not previously recovered. The amount so deducted shall be paid to the jurisdiction under whose program such overpayment was made. Any such deduction shall be made only in accordance with the same procedures relating to notice and opportunity for a hearing as apply to the recovery of overpayments of regular unemployment compensation paid by such State.

(2) Any State may enter into an agreement with the Secretary of Labor under which—

(A) the State agrees to recover from unemployment benefits otherwise payable to an individual by such State any overpayments made under an unemployment benefit program of the United States to such individual and not previously recovered, in accordance with paragraph (1), and to pay such amounts recovered to the United States for credit to the appropriate account, and

(B) the United States agrees to allow the State to recover from unemployment benefits otherwise payable to an individual under an unemployment benefit program of the United States any overpayments made by such State to such individual under a State unemployment benefit program and not previously recovered, in accordance with the same procedures as apply under paragraph (1).

(3) For purposes of this subsection, "unemployment benefits" means unemployment compensation, trade adjustment allowances, and other unemployment assistance.

(h)(1) The State agency charged with the administration of the State law shall take such actions (in such manner as may be provided in the agreement between the Secretary of Health and Human Services and the Secretary of Labor under section 453(e)(3)) as may be necessary to enable the Secretary of Health and Human Services to obtain prompt access to any wage and unemployment compensation claims information (including any information that might be useful in locating an absent parent or such parent's employer) for use by the Secretary of Health and Human Services, for purposes of section 453, in carrying out the child support enforcement program under title IV.

(2) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirement of paragraph (1), the Secretary of Labor shall notify such State agency that further payments will not be made to the State until such Secretary is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, such Secretary shall make no further certification to the Secretary of the Treasury with respect to such State.

(i)(1) The State agency charged with the administration of the State law—

(A) shall disclose, upon request and on a reimbursable basis, only to officers and employees of the Department of Housing and Urban Development and to representatives of a public housing agency, any of the following information contained in the records of such State agency with respect to individuals applying for or participating in any housing assistance program administered by the Department who have signed an appropriate consent form approved by the Secretary of Housing and Urban Development—

(i) wage information, and

(ii) whether an individual is receiving, has received, or has made application for, unemployment compensation, and the amount of any such compensation being received (or to be received) by such individual, and

(B) shall establish such safeguards as are necessary (as determined by the Secretary of Labor in regulations) to ensure that information disclosed under subparagraph (A) is used only for purposes of determining an individual's eligibility for benefits, or the amount of benefits, under a housing assistance program of the Department of Housing and Urban Development.

(2) The Secretary of Labor shall prescribe regulations governing how often and in what form information may be disclosed under paragraph (1)(A).

(3) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirements of paragraph (1), the Secretary of Labor shall notify such State agency that further payments will not be made to the State until he or she is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, he or she shall make no future certification to the Secretary of the Treasury with respect to such State.

(4) For purposes of this subsection, the term "public housing agency" means any agency described in section 3(b)(6) of the United States Housing Act of 1937[11].

(5) The provisions of this subsection shall cease to be effective beginning on October 1, 1994.

JUDICIAL REVIEW

Sec. 304. [42 U.S.C. 504] (a) Whenever the Secretary of Labor—

(1) finds that a State law does not include any provision specified in section 303(a), or

(2) makes a finding with respect to a State under subsection (b), (c), (d), (e), (h), or (i) of section 303,

such State may, within 60 days after the Governor of the State has been notified of such action, file with the United States court of appeals for the circuit in which such State is located or with the United States Court of Appeals for the District of Columbia, a petition for review of such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary of Labor. The Secretary of Labor thereupon shall file in the court the record of the proceedings on which he based his action as provided in section 2112 of title 28, United States Code.

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[11] P.L. 75-412.

(b) The findings of fact by the Secretary of Labor, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Secretary of Labor to take further evidence and the Secretary of Labor may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(c) The court shall have jurisdiction to affirm the action of the Secretary of Labor or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28 of the United States Code.

(d)(1) The Secretary of Labor shall not withhold any certification for payment to any State under section 302 until the expiration of 60 days after the Governor of the State has been notified of the action referred to in paragraph (1) or (2) of subsection (a) or until the State has filed a petition for review of such action, whichever is earlier.

(2) The commencement of judicial proceedings under this section shall stay the Secretary's action for a period of 30 days, and the court may thereafter grant interim relief if warranted, including a further stay of the Secretary's action and including such other relief as may be necessary to preserve status or rights.

TITLE IV—GRANTS TO STATES FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN AND FOR CHILD-WELFARE SERVICES[1]

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[1] Title IV of the Social Security Act is administered by the Department of Health and Human Services (formerly Department of Health, Education, and Welfare). The Office of Family Assistance administers benefit payments under Title IV, Parts A and C. The Administration for Public Services, Office of Human Development Services, administers social services under Title IV, Parts B and E. The Office of Child Support Enforcement administers the child support program under Title IV, Part D.

Title IV appears in the United States Code as §§601-687, subchapter IV, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services relating to Title IV are contained in chapters II, III, and XIII, Title 45, Code of Federal Regulations. Regulations of the Secretary of Labor relating to Title IV are contained in subtitle A, Title 29, and chapter 29, Title 41, Code of Federal Regulations.

See Vol. II, 31 U.S.C. 3720 and 3720A, with respect to collection of payments due to Federal agencies.

See Vol. II, 31 U.S.C. 6504-6505, with respect to intergovernmental cooperation.

See Vol. II, 31 U.S.C. 7501-7507, with respect to uniform audit requirements for State and local governments receiving Federal financial assistance.

See Vol. II, P.L. 82-183, §618, which prohibits denial of grants-in-aid under certain conditions.

See Vol. II, P.L. 88-352, §601, for prohibition against discrimination in federally assisted programs.

See Vol. II, P.L. 89-73, §213, with respect to eligibility for Federal surplus property.

See Vol. II, P.L. 89-97, §121(b), with respect to restrictions on payment to a State receiving payments under Title XIX.

See Vol. II, P.L. 94-241, §1, for §502(a)(1) of H.J. Res. 549, with respect to participation by the Commonwealth of the Northern Mariana Islands on the same basis as Guam.

See Vol. II, P.L. 95-521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 97-300, §106(e)(2), with respect to performance standards; §202(b)(3)(B), with respect to governors' incentive grants; and §§501-505, with respect to the payment of a bonus for the successful job placement of certain employable dependent individuals.

See Vol. II, P.L. 98-378, §23, with respect to the sense of the Congress that State and local governments should focus on the problems of child custody, child support, and related domestic issues.

See Vol. II, P.L. 99-401, §205(a)(1)(B), with respect to State agencies' involvement in temporary child care for children with disabilities and crisis nurseries.

See Vol. II, P.L. 99-570, §11005(d), with respect to treatment of homeless individuals eligible under SSI and Medicaid programs.

See Vol. II, P.L. 100-203, §9118, with respect to homeless AFDC families; §9121, with respect to a demonstration project to test the operation of Washington State's Family Independence Program; §9122, with respect to a demonstration project to test a New York State program; and §9138, with respect to a study of infants and children with AIDS in foster care (which the Secretary shall conduct).

See Vol. II, P.L. 100-204, §724(d), with respect to furnishing information to the United States Commission on Improving the Effectiveness of the United Nations; and §725(b), with respect to the detailing of Government personnel.

See Vol. II, P.L. 100-235, §§5-8, with respect to responsibilities of each Federal agency for computer systems security and privacy.

See Vol. II, P.L. 100-485, §126, with respect to a Commission on interstate child support; §128, with respect to a study of child-rearing costs; §302(e), with respect to a study on effects of extending eligibility for child care; §406, with respect to a study of new national approaches to welfare benefits for low-income families with children; §501, with respect to family support demonstration projects; §502, with respect to demonstration projects to encourage States to employ parents receiving AFDC as paid child care providers; §504, with respect to demonstration projects to address child access problems; §505, with respect to demonstration projects to expand the number of job opportunities available to certain low-income individuals; §506, with respect to demonstration projects to provide counseling and services to high-risk teenagers; and §608(e), with respect to the extension of a pilot program.

See Vol. II, P.L. 100-690, §5301(a)(1)(C) and (d)(1)(B), with respect to benefits of drug traffickers and possessors.

See Vol. II, P.L. 101-239, §8015, with respect to demonstration of effectiveness of Minnesota family investment plan; §10404, with respect to a demonstration project using volunteer senior aides to provide medical assistance and support to families with disabled or ill children; §10406,

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with respect to treatment of triennial reviews of State foster care protections for fiscal years before October 1, 1990.

See Vol. II, P.L. 101-166, §204, with respect to abortions.

See Vol. II, P.L. 101-508, §13301 and 13302, with respect to the OASDI Trust Funds.

[2] This table of contents does not appear in the law.

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PART A—AID TO FAMILIES WITH DEPENDENT CHILDREN[3]

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[3] See Vol. II, P.L. 73-30, §3(a), with respect to the supply of information.

See Vol. II, P.L. 88-525, §11(e), with respect to inquiry into the need for food stamps.

See Vol. II, P.L. 94-566, §508(b), with respect to provision for reimbursement of expenses of State employment offices.

See Vol. II, P.L. 95-30, §401(a), with respect to the work incentive program.

See Vol. II, P.L. 96-223, §102, with respect to allocation of funds for programs to assist AFDC recipients.

See Vol. II, P.L. 97-248, §159, with respect to exclusion from income of certain payments made by a State.

See Vol. II, P.L. 98-378, §22, with respect to the Wisconsin Child Support Initiative.

APPROPRIATION

SECTION 401. [42 U.S.C. 601] For the purpose of encouraging the care of dependent children in their own homes or in the homes of relatives by enabling each State to furnish financial assistance and rehabilitation and other services, as far as practicable under the conditions in such State, to needy dependent children and the parents or relatives with whom they are living to help maintain and strengthen family life and to help such parents or relatives to attain or retain capability for the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this part. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for aid and services to needy families with children.

STATE PLANS FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN

SEC. 402. [42 U.S.C. 602] (a) A State plan for aid and services to needy families with children must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State;

(3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan;

(4) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid to families with dependent children is denied or is not acted upon with reasonable promptness;

(5) provide such methods of administration (including after January 1, 1940, methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary

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See Vol. II, P.L. 99-272, §12301, with respect to AFDC quality control studies and penalty moratorium.

See Vol. II, P.L. 100-485, §405, with respect to a Congressional Budget Office study on implementation of a national minimum payment standard.

See Vol. II, P.L. 100-628, §902, with respect to a review of policy governing use of AFDC funds to meet emergency needs of families eligible for AFDC through emergency assistance or special needs payments and a report to Congress; and §903, with respect to demonstration projects to reduce the number of homeless AFDC families in welfare hotels.

See Vol. II, P.L. 100-647, §8102, with respect to the Secretary's review of the policy governing use of AFDC funds to meet emergency needs of families eligible for AFDC through emergency assistance or special needs payments and a report to Congress.

See Vol. II, P.L. 101-239, §8004(g), with respect to a study of negative case actions; and §8005, with respect to emergency assistance and AFDC special needs.

may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) except as may be otherwise provided in paragraph (8) or (31) and section 415, provide that the State agency—

(A) shall, in determining need, take into consideration any other income and resources of any child or relative claiming aid to families with dependent children, or of any other individual (living in the same home as such child and relative) whose needs the State determines should be considered in determining the need of the child or relative claiming such aid;

(B) shall determine ineligible for aid any family the combined value of whose resources (reduced by any obligations or debts with respect to such resources) exceeds $1,000 or such lower amount as the State may determine, but not including as a resource for purposes of this subparagraph[4] (i) a home owned and occupied by such child, relative, or other individual and so much of the family member's ownership interest in one automobile as does not exceed such amount as the Secretary may prescribe, (ii) under regulations prescribed by the Secretary, burial plots (one for each such child, relative, and other individual), and funeral agreements or (iii) for such period or periods of time as the Secretary may prescribe, real property which the family is making a good-faith effort to dispose of, but any aid payable to the family for any such period shall be conditioned upon such disposal, and any payments of such aid for that period shall (at the time of the disposal) be considered overpayments to the extent that they would not have been made had the disposal occurred at the beginning of the period for which the payments of such aid were made; and

(C) may, in the case of a family claiming or receiving aid under this part for any month, take into consideration as income (to the extent the State determines appropriate, as specified in such plan, and notwithstanding any other provision of law)—

(i) an amount not to exceed the value of the family's monthly allotment of food stamp coupons, to the extent such value duplicates the amount for food included in the maximum amount that would be payable under the State plan to a family of the same composition with no other income; and

(ii) an amount not to exceed the value of any rent or housing subsidy provided to such family, to the extent such value duplicates the amount for housing included in the maximum amount that would be payable under the State plan to a family of the same composition with no other income;[5]

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[4] As in original. Should have punctuation to signal beginning of a series.

[5] See Vol. II, 10 U.S.C. 2546, with respect to shelter for the homeless at military installations.

See Vol. II, P.L. 79-396, §12(e), with respect to exclusion from income and resources of assistance to children under that act.

See Vol. II, P.L. 81-171, §521(a)(1)(E), with respect to exclusion from income and resources of certain assistance rendered to provide occupant-owned, rental and cooperative housing.

See Vol. II, P.L. 88-525, §8(b), with respect to exclusion from income and resources of the value of

(8)(A) provide that, with respect to any month, in making the determination under paragraph (7), the State agency—

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food stamps.

See Vol. II, P.L. 89-73, §210(b), with respect to exclusion from income of the costs of any project under that act.

See Vol. II, P.L. 89-329, §479B, with respect to exclusion from income or resources of certain student financial assistance; and §481(a), with respect to the definition of "institution of higher education".

See Vol. II, P.L. 89-642, §11(b), with respect to exclusion from income and resources of the value of assistance to children under that act.

See Vol. II, P.L. 90-248, §248(c), effective July 1, 1969, with respect to income disregards applicable to Guam, Puerto Rico, and the Virgin Islands.

See Vol. II, P.L. 91-646, §216, with respect to exclusion from income of payments made under that act.

See Vol. II, P.L. 93-112, §613(c), with respect to conditional exclusion of wages, allowances, transportation reimbursement, and attendant care costs.

See Vol. II, P.L. 93-113, §404(g), with respect to exclusion from income and resources of payments to volunteers under that act.

See Vol. II, P.L. 93-134, §1, with respect to applicability of this public law, and §§7 and 8, with respect to exclusion from income and resources of certain judgment funds to any Indian tribe.

See Vol. II, P.L. 93-288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 94-114, §6, with respect to exclusion from income and resources of property and receipts from submarginal land to certain Indians.

See Vol. II, P.L. 95-433, §2, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 95-498, §6, with respect to an income and resources exclusion applicable to the Pueblo of Santa Ana Indians, New Mexico.

See Vol. II, P.L. 95-499, §6, with respect to an income and resources exclusion applicable to the Pueblo of Zia Indians, New Mexico.

See Vol. II, P.L. 95-557, §410(b), with respect to exclusion from income of services (but not of wages) provided to a public housing resident or to a resident of a housing project assisted under the "Housing Act of 1959" (Vol. II, P.L. 86-372, §202).

See Vol. II, P.L. 97-35, §2605(f), with respect to exclusion from income and resources of home energy assistance payments or allowances.

See Vol. II, P.L. 98-64, §2(a), with respect to exclusion from income and resources of per capita payments to Indians.

See Vol. II, P.L. 98-181, §221, with respect to consideration of utility payments made by tenants in assisted housing.

See Vol. II, P.L. 98-432, §5(c), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98-500, §8, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98-602, §106(d), with respect to exclusion from income and resources of certain funds distributed per capita.

See Vol. II, P.L. 99-130, §8, with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99-146, §6(b), with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99-264, §16, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99-346, §6(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99-377, §4(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 100-139, §4(h)(6), with respect to exclusion of benefits as basis for denial of eligibility.

See Vol. II, P.L. 100-383, §§105(f)(2) and 206(d)(2), with respect to exclusion from income and resources of certain payments to certain individuals.

See Vol. II, 31 U.S.C. 3803(c)(2)(C), with respect to benefits not affected by P.L. 100-383.

See Vol. II, P.L. 100-407, §105(c), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100-409, §5, with respect to the effect of this Act on P.L. 92-203 or P.L. 96-487.

See Vol. II, P.L. 100-411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100-581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 101-41, §10(b)-(d), with respect to eligibility for Federal programs and treatment of funds, assets, and income.

See Vol. II, P.L. 101-42, §3, with respect to the restoration of Federal recognition, rights, and privileges.

See Vol. II, P.L. 101-201, with respect to Agent Orange settlement payments.

See Vol. II, P.L. 101-239, §10405, with respect to Agent Orange settlement payments excluded from countable income and resources under Federal means-tested programs.

See Vol. II, P.L. 101-277, §8(b), with respect to exclusion, from income or resources, of funds held in trust or distributed to Seminole Indians.

(i) shall disregard all of the earned income of each dependent child receiving aid to families with dependent children who is (as determined by the State in accordance with standards prescribed by the Secretary) a full-time student or a part-time student who is not a full-time employee attending a school, college, or university, or a course of vocational or technical training designed to fit him for gainful employment;

(ii) shall disregard from the earned income of any child or relative applying for or receiving aid to families with dependent children, or of any other individual (living in the same home as such relative and child) whose needs are taken into account in making such determination, the first $90[6] of the total of such earned income for such month;

(iii) after applying the other clauses of this subparagraph,[7] shall disregard from the earned income of any child, relative, or other individual specified in clause (ii), an amount equal to expenditures for care in such month for a dependent child, or an incapacitated individual living in the same home as the dependent child, receiving aid to families with dependent children and requiring such care for such month, to the extent that such amount (for each such dependent child or incapacitated individual) does not exceed $175[8] (or such lesser amount as the Secretary may prescribe in the case of an individual not engaged in full-time employment or not employed throughout the month), or, in the case such child is under age 2, $200[9];

(iv) shall disregard from the earned income of any child or relative receiving aid to families with dependent children, or of any other individual (living in the same home as such relative and child) whose needs are taken into account in making such determination, an amount equal to (I) the first $30 of the total of such earned income not disregarded under any other clause of this subparagraph plus (II) one-third of the remainder thereof[10];

(v) may disregard the income of any dependent child applying for or receiving aid to families with dependent children which is derived from a program carried out under the Job Training Partnership Act[11] (as originally enacted[12]), but only in such amounts, and for such period of time (not to exceed six months with respect to earned income) as the Secretary may provide in regulations;

(vi) shall disregard the first $50 of any child support payments for such month received in that month, and the first $50 of child support payments for each prior month received in that month if such payments were made by the absent parent in the month when due, with respect to the dependent child or children in any family applying for or receiving aid to families with dependent children (including support payments collected and paid to the family under section 457(b));

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[6] P.L. 100-485, §402(b), struck out "$75" and substituted "$90", effective October 1, 1989.

[7] P.L. 100-485, §402(a)(1), inserted "after applying the other clauses of this subparagraph,", effective October 1, 1989.

[8] P.L. 100-485, §402(a)(2), struck out "$160" and substituted "$175", effective October 1, 1989.

[9] P.L. 100-485, §402(a)(3), inserted ", or, in the case such child is under age 2, $200", effective October 1, 1989.

[10] P.L. 100-485, §202(b)(1), struck out "(but excluding, for purposes of this subparagraph, earned income derived from participation on a project maintained under the programs established by section 432(b)(2) and (3))". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

[11] P.L. 97-300.

[12] See Vol. II, P.L. 97-404, §6, with respect to the interpretation of "originally enacted".

(vii) may disregard all or any part of the earned income of a dependent child who is a full-time student and who is applying for aid to families with dependent children, but only if the earned income of such child is excluded for such month in determining the family's total income under paragraph (18); and

(viii) shall disregard any refund of Federal income taxes made to a family receiving aid to families with dependent children by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit) and any payment made to such a family by an employer under section 3507 of such Code (relating to advance payment of earned income credit); and[13]

(B) provide that (with respect to any month) the State agency—

(i) shall not disregard, under clause (ii), (iii), or (iv) of subparagraph (A), any earned income of any one of the persons specified in subparagraph (A)(ii) if such person—

(I) terminated his employment or reduced his earned income without good cause within such period (of not less than thirty days) preceding such month as may be prescribed by the Secretary;

(II) refused without good cause, within such period preceding such month as may be prescribed by the Secretary, to accept employment in which he is able to engage which is offered through the public employment offices of the State, or is otherwise offered by an employer if the offer of such employer is determined by the State or local agency administering the State plan, after notification by the employer, to be a bona fide offer of employment; or

(III) failed without good cause to make a timely report (as prescribed by the State plan pursuant to paragraph (14)) to the State agency of earned income received in such month; and

(ii)(I) shall not disregard—

(a) under subclause (II) of subparagraph (A)(iv), in a case where such subclause has already been applied to the income of the persons involved for four consecutive months while they were receiving aid under the plan, or

(b) under subclause (I) of subparagraph (A)(iv), in a case where such subclause has already been applied to the income of the persons involved for twelve consecutive months while they were receiving aid under the plan, any earned income of any of the persons specified in subparagraph (A)(ii), if, with respect to such month, the income of the persons so specified was in excess of their need, as determined by the State agency pursuant to paragraph (7) (without regard to subparagraph (A)(iv) of this paragraph), unless the persons received aid under the plan in one or more of the four months preceding such month; and

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[13] P.L. 100-485, §402(c)(1)(B), added clause (viii), effective October 1, 1989.

(II) in the case of the earned income of a person with respect to whom subparagraph (A)(iv) has been applied for four consecutive months, shall not apply the provisions of subclause (II) of such subparagraph to any month after such month, or apply the provisions of subclause (I) of such subparagraph to any month after the eighth month following such month, for so long as he continues to receive aid under the plan, and shall not apply the provisions of either such subclause to any month thereafter until the expiration of an additional period of twelve consecutive months during which he is not a recipient of such aid; and

(C) provide that in implementing this paragraph the term "earned income" shall mean gross earned income, prior to any deductions for taxes or for any other purposes;

(9) provide safeguards which restrict the use or disclosure of information concerning applicants or recipients to purposes directly connected with (A) the administration of the plan of the State approved under this part (including activities under part F)[14], the plan or program of the State under part B[15], D, or E[16] of this title or under title I, X, XIV, XVI, XIX, or XX, or the supplemental security income program established by title XVI, (B) any investigation, prosecution, or criminal or civil proceeding, conducted in connection with the administration of any such plan or program, (C) the administration of any other Federal or federally assisted program which provides assistance, in cash or in kind, or services, directly to individuals on the basis of need,[17] (D) any audit or similar activity conducted in connection with the administration of any such plan or program by any governmental entity which is authorized by law to conduct such audit or activity, and (E) reporting and providing information pursuant to paragraph (16) to appropriate authorities with respect to known or suspected child abuse or neglect[18]; and the safeguards so provided shall prohibit disclosure, to any committee or legislative body (other than an entity referred to in clause (D) with respect to an activity referred to in such clause), of any information which identifies by name or address any such applicant or recipient; but such safeguards shall not prevent the State agency or the local agency responsible for the administration of the State plan in the locality (whether or not the State has enacted

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[14] P.L. 100-485, §202(b)(2)(A), inserted "(including activities under part F)". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

[15] P.L. 100-485, §202(b)(2)(B), struck out ", C,". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

[16] P.L. 101-508, §5055(a), struck out "or D" and substituted ", D, or E", effective November 5, 1990.

[17] P.L. 101-508, §5054(a)(2)(A), struck out "and".

[18] P.L. 101-508, §5054(a)(2)(B), added ", and" and subparagraph (E), applicable to benefits for months beginning on or after the first day of the 6th calendar month following November 1990.

legislation allowing public access to Federal welfare records) from furnishing a State or local law enforcement officer, upon his request, with the current address of any recipient if the officer furnishes the agency with such recipient's name and social security account number and satisfactorily demonstrates that such recipient is a fugitive felon, that the location or apprehension of such felon is within the officer's official duties, and that the request is made in the proper exercise of those duties;[19]

(10)(A) provide that all individuals wishing to make application for aid to families with dependent children shall have opportunity to do so, and that aid to families with dependent children shall, subject to paragraphs (25) and (26), be furnished with reasonable promptness to all eligible individuals; and

(B) provide that an application for aid under the plan will be effective no earlier than the date such application is filed with the State agency or local agency responsible for the administration of the State plan, and the amount payable for the month in which the application becomes effective, if such application becomes effective after the first day of such month, shall bear the same ratio to the amount which would be payable if the application had been effective on the first day of such month as the number of days in the month including and following the effective date of the application bears to the total number of days in such month;

(11) provide for prompt notice (including the transmittal of all relevant information) to the State child support collection agency (established pursuant to part D of this title) of the furnishing of aid to families with dependent children with respect to a child who has been deserted or abandoned by a parent (including a child born out of wedlock without regard to whether the paternity of such child has been established);

(12) provide, effective October 1, 1950, that no aid will be furnished any individual under the plan with respect to any period with respect to which he is receiving old-age assistance under the State plan approved under section 2 of this Act;

(13) at the option of the State, but only with respect to any one or more categories of families required to report monthly to the State agency pursuant to paragraph (14), provide that—[20]

(A) except as provided in subparagraph (B), the State agency (i) will determine a family's eligibility for aid for a month on the basis of the family's income, composition, resources, and other similar relevant circumstances during such month, and (ii) will determine the amount of such aid on the basis of the income and other relevant circumstances in the first or, at the option of the State (but only where the Secretary determines it to be appropriate, in the case of families who are required to report monthly to the State agency pursuant to paragraph (14)), second month preceding such month; and

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[19] See Vol. II, P.L. 82-183, §618, the "Jenner Amendment", with respect to a condition under which grant-in-aid or other payment may not be withheld.

[20] P.L. 101-508, §5051(b), struck out "with respect to families who are required to report monthly to the State agency pursuant to paragraph (14) (and at the option of the State with respect to other families), provide that—" and substituted "at the option of the State, but only with respect to any one or more categories of families required to report monthly to the State agency pursuant to paragraph (14), provide that—", effective with respect to reports pertaining to, or aid payable for, months beginning in or after October 1990.

(B) in the case of the first month, or at the option of the State (but only where the Secretary determines it to be appropriate, in the case of families who are required to report monthly to the State agency pursuant to paragraph (14)), the first and second months, in a period of consecutive months for which aid is payable, the State agency will determine the amount of aid on the basis of the family's income and other relevant circumstances in such first or second month;

(14) provide, at the option of the State and with respect to such category or categories as the State may select and identify in its State plan (A)[21] that the State agency will require each family to which it furnishes aid to families with dependent children (or to which it would provide such aid but for paragraph (22) or (32)) to report, as a condition to the continued receipt of such aid (or to continuing to be deemed to be a recipient of such aid), each month to the State agency on—

(i) the income received, family composition, and other relevant circumstances during the prior month; and

(ii) the income and resources it expects to receive, or any changes in circumstances affecting continued eligibility or benefit amount, that it expects to occur, in that month (or in future months);

except that[22] the State may select categories of recipients who may report at specified less frequent intervals[23]; and

(B) that, in addition to whatever action may be appropriate based on other reports or information received by the State agency, the State agency will take prompt action to adjust the amount of assistance payable, as may be appropriate, on the basis of the information contained in the report (or upon the failure of the family to furnish a timely report), and will give an appropriate explanatory notice, concurrent with its action, to the family;

(15) provide (A) for the development of a program, for each appropriate relative and dependent child receiving aid under the plan and for each appropriate individual (living in the same home as a relative and child receiving such aid) whose needs are taken into account in making the determination under paragraph (7), for preventing or reducing the incidence of births out of wedlock and otherwise strengthening family life, and for implementing such program by assuring that in all appropriate cases (including minors who can be considered to be sexually active) family planning services are offered to them and are

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[21] P.L. 101-508, §5051(a)(1), struck out "with respect to families in the category of recent work history or earned income cases (and at the option of the State with respect to families in other categories), (A) provide" and substituted "provide, at the option of the State and with respect to such category or categories as the State may select and identify in its State plan (A)", effective with respect to reports pertaining to, or aid payable for, months beginning in or after October 1990.

[22] P.L. 101-508, §5051(a)(2), struck out "(with the prior approval of the Secretary in recent work history and earned income cases)", effective with respect to reports pertaining to, or aid payable for, months beginning in or after October 1990.

[23] P.L. 101-508, §5051(a)(3), struck out "upon a determination that to require individuals in such categories to report monthly would result in unwarranted expenditures for administration of this paragraph", effective with respect to reports pertaining to, or aid payable for, months beginning in or after October 1990.

provided promptly (directly or under arrangements with others) to all individuals voluntarily requesting such services, but acceptance of family planning services provided under the plan shall be voluntary on the part of such members and individuals and shall not be a prerequisite to eligibility for or the receipt of any other service under the plan; and (B) to the extent that services provided under this paragraph are furnished by the staff of the State agency or the local agency administering the State plan in each of the political subdivisions of the State, for the establishment of a single organizational unit in such State or local agency, as the case may be, responsible for the furnishing of such services;

(16) provide that the State agency will—

(A) report to an appropriate agency or official, known or suspected instances of physical or mental injury, sexual abuse or exploitation, or negligent treatment or maltreatment of a child receiving aid under this part under circumstances which indicate that the child's health or welfare is threatened thereby; and

(B) provide such information with respect to a situation described in subparagraph (A) as the State agency may have;[24]

(17) provide that if a child or relative applying for or receiving aid to families with dependent children, or any other person whose need the State considers when determining the income of a family, receives in any month an amount of earned or unearned income which, together with all other income for that month not excluded under paragraph (8), exceeds the State's standard of need applicable to the family of which he is a member—

(A) such amount of income shall be considered income to such individual in the month received, and the family of which such person is a member shall be ineligible for aid under the plan for the whole number of months that equals (i) the sum of such amount and all other income received in such month, not excluded under paragraph (8), divided by (ii) the standard of need applicable to such family, and

(B) any income remaining (which amount is less than the applicable monthly standard) shall be treated as income received in the first month following the period of ineligibility specified in subparagraph (A);[25]

except that the State may at its option recalculate the period of ineligibility otherwise determined under subparagraph (A) (but only with respect to the remaining months in such period) in any one or more of the following cases: (i) an event occurs which, had the family been receiving aid under the State plan for the month of the occurrence, would result in a change in the amount of aid payable for such month under the plan, or (ii) the income received has become unavailable to the members of the family for reasons that were beyond the control of such members, or (iii) the family incurs, becomes responsible for, and pays medical expenses (as allowed by the State) in a month of ineligibility determined under subparagraph (A) (which expenses may be considered as an offset against the amount of income received in the first month of such ineligibility);

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[24] P.L. 101-508, §5054(a)(1), amended paragraph (16) in its entirety, applicable to benefits for months beginning or or after May 1, 1991. Until then, paragraph (16) read as follows:

"(16) provide that where the State agency has reason to believe that the home in which a relative and child receiving aid reside is unsuitable for the child because of the neglect, abuse, or exploitation of such child it shall bring such condition to the attention of the appropriate court or law enforcement agencies in the State, providing such data with respect to the situation it may have;".

See Vol. II, P.L. 95-608, §§2-113, with respect to Indian child welfare.

[25] See Vol. II, P.L. 97-248, §159, with respect to exclusion from income of certain payments made by a State.

(18) provide that no family shall be eligible for aid under the plan for any month if, for that month, the total income of the family (other than payments under the plan), without application of paragraph (8), other than paragraph (8)(A)(v), exceeds 185 percent of the State's standard of need for a family of the same composition, except that in determining the total income of the family the State may exclude any earned income of a dependent child who is a full-time student, in such amounts and for such period of time (not to exceed 6 months) as the State may determine;

(19) provide—

(A) that the State has in effect and operation a job opportunities and basic skills training program which meets the requirements of part F;

(B) that—

(i) the State will (except as otherwise provided in this paragraph or part F), to the extent that the program is available in the political subdivision involved and State resources otherwise permit—

(I) require all recipients of aid to families with dependent children in such subdivision with respect to whom the State guarantees child care in accordance with section 402(g) to participate in the program; and

(II) allow applicants for and recipients of aid to families with dependent children (and individuals who would be recipients of such aid if the State had not exercised the option under section 407(b)(2)(B)(i))[26] who are not required under subclause (I) to participate in the program to do so on a voluntary basis;

(ii) in determining the priority of participation by individuals from among those groups described in clauses (i), (ii), (iii), and (iv) of section 403(l)(2)(B), the State will give first consideration to applicants for or recipients of aid to families with dependent children within any such group who volunteer to participate in the program;

(iii) if an exempt participant drops out of the program without good cause after having commenced participation in the program, he or she shall thereafter not be given priority so long as other individuals are actively seeking to participate; and

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[26] P.L. 100-485, §401(b)(2), inserted "(and individuals who would be recipients of such aid if the State had not exercised the option under section 407(b)(2)(B)(i))", effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law as in effect immediately before the effective date of this amendment shall apply as if this amendment had never been made.

(iv) the State need not require or allow participation of an individual in the program if as a result of such participation the amount payable to the State for quarters in a fiscal year with respect to the program would be reduced pursuant to section 403(l)(2);

(C) that an individual may not be required to participate in the program if such individual—

(i) is ill, incapacitated, or of advanced age;

(ii) is needed in the home because of the illness or incapacity of another member of the household;

(iii) subject to subparagraph (D)—

(I) is the parent or other relative of a child under 3 years of age (or, if so provided in the State plan, under any age that is less than 3 years but not less than one year) who is personally providing care for the child, or

(II) is the parent or other relative personally providing care for a child under 6 years of age, unless the State assures that child care in accordance with section 402(g) will be guaranteed and that participation in the program by the parent or relative will not be required for more than 20 hours a week;

(iv) works 30 or more hours a week;

(v) is a child who is under age 16 or attends, full-time, an elementary, secondary, or vocational (or technical) school;

(vi) is pregnant if it has been medically verified that the child is expected to be born in the month in which such participation would otherwise be required or within the 6-month period immediately following such month; or

(vii) resides in an area of the State where the program is not available;

(D) that, in the case of a family eligible for aid to families with dependent children by reason of the unemployment of the parent who is the principal earner, subparagraph (C)(iii) shall apply only to one parent, except that, in the case of such a family, the State may at its option make such subparagraph inapplicable to both of the parents (and require their participation in the program) if child care in accordance with section 402(g) is guaranteed with respect to the family;

(E) that—

(i) to the extent that the program is available in the political subdivision involved and State resources otherwise permit, in the case of a custodial parent who has not attained 20 years of age, has not successfully completed a high-school education (or its equivalent), and is required to participate in the program (including an individual who would otherwise be exempt from participation in the program solely by reason of subparagraph (C)(iii)), the State agency (subject to clause (ii)) will require such parent to participate in an educational activity; and

(ii) the State agency may—

(I) require a parent described in clause (i) (notwithstanding the part-time requirement in subparagraph (C)(iii)(II)) to participate in educational activities directed toward the attainment of a high school diploma or its equivalent on a full-time (as defined by the educational provider) basis,

(II) establish criteria in accordance with regulations of the Secretary under which custodial parents described in clause (i) who have not attained 18 years of age may be exempted from the school attendance requirement under such clause, or

(III) require a parent described in clause (i) who is age 18 or 19 to participate in training or work activities (in lieu of the educational activities under such clause) if such parent fails to make good progress in successfully completing such educational activities or if it is determined (prior to any assignment of the individual to such educational activities) pursuant to an educational assessment that participation in such educational activities is inappropriate for such parent;

(F) that—

(i) if the parent or other caretaker relative or any dependent child in the family is attending (in good standing) an institution of higher education (as defined in section 481(a) of the Higher Education Act of 1965), or a school or course of vocational or technical training (not less than half time) consistent with the individual's employment goals, and is making satisfactory progress in such institution, school, or course, at the time he or she would otherwise commence participation in the program under this section, such attendance may constitute satisfactory participation in the program (by that caretaker or child) so long as it continues and is consistent with such goals;

(ii) any other activities in which an individual described in clause (i) participates may not be permitted to interfere with the school or training described in that clause;

(iii) the costs of such school or training shall not constitute federally reimbursable expenses for purposes of section 403; and

(iv) the costs of day care, transportation, and other services which are necessary (as determined by the State agency) for such attendance in accordance with section 402(g) are eligible for Federal reimbursement;

(G) that—

(i) if an individual who is required by the provisions of this paragraph to participate in the program or who is so required by reason of the State's having exercised the option under subparagraph (D) fails without good cause to participate in the program or refuses without good cause to accept employment in which such individual is able to engage which is offered through the public employment offices of the State, or is otherwise offered by an employer if the offer of such employer is determined to be a bona fide offer of employment—

(I) the needs of such individual (whether or not section 407 applies) shall not be taken into account in making the determination with respect to his or her family under paragraph (7) of this subsection, and if such individual is a parent or other caretaker relative, payments of aid for any dependent child in the family in the form of payments of the type described in section 406(b)(2) (which in such a case shall be without regard to clauses (A) through (D) thereof) will be made unless the State agency, after making reasonable efforts, is unable to locate an appropriate individual to whom such payments can be made; and

(II) if such individual is a member of a family which is eligible for aid to families with dependent children by reason of section 407, and his or her spouse is not participating in the program, the needs of such spouse shall also not be taken into account in making such determination;

(ii) any sanction described in clause (i) shall continue—

(I) in the case of the individual's first failure to comply, until the failure to comply ceases;

(II) in the case of the individual's second failure to comply, until the failure to comply ceases or 3 months (whichever is longer); and

(III) in the case of any subsequent failure to comply, until the failure to comply ceases or 6 months (whichever is longer);

(iii) the State will promptly remind any individual whose failure to comply has continued for 3 months, in writing, of the individual's option to end the sanction by terminating such failure; and

(iv) no sanction shall be imposed under this subparagraph—

(I) on the basis of the refusal of an individual described in subparagraph (C)(iii)(II) to accept employment, if the employment would require such individual to work more than 20 hours a week, or

(II) on the basis of the refusal of an individual to participate in the program or accept employment, if child care (or day care for any incapacitated individual living in the same home as a dependent child) is necessary for an individual to participate in the program or accept employment, such care is not available, and the State agency fails to provide such care; and

(H) the State agency may require a participant in the program to accept a job only if such agency assures that the family of such participant will experience no net loss of cash income resulting from acceptance of the job; and any costs incurred by the State agency as a result of this subparagraph shall be treated as expenditures with respect to which section 403(a)(1) or 403(a)(2) applies;[27]

(20) provide that the State has in effect a State plan for foster care and adoption assistance approved under part E of this title;[28]

(21) provide—

(A) that, for purposes of this part, participation in a strike shall not constitute good cause to leave, or to refuse to seek or accept employment; and

(B)(i) that aid to families with dependent children is not payable to a family for any month in which any caretaker relative with whom the child is living is, on the last day of such month, participating in a strike, and (ii) that no individual's needs shall be included in determining the amount of aid payable for any month to a family under the plan if, on the last day of such month, such individual is participating in a strike;

(22) provide that the State agency will promptly take all necessary steps to correct any overpayment or underpayment of aid under the State plan, and, in the case of—

(A) an overpayment to an individual who is a current recipient of such aid (including a current recipient whose overpayment occurred during a prior period of eligibility), recovery will be made by repayment by the individual or by reducing the amount of any future aid payable to the family of which he is a member, except that such recovery shall not result in the reduction of aid payable for any month, such that the aid, when added to such family's liquid resources and to its income (without application of paragraph (8)), is less than 90 percent of the amount payable under the State plan to a family of the same composition with no other income (and, in the case of an individual to whom no payment is made for a month solely by reason of recovery of an overpayment, such individual shall be deemed to be a recipient of aid for such month);

(B) an overpayment to any individual who is no longer receiving aid under the plan, recovery shall be made by appropriate action under State law against the income or resources of the individual or the family; and

(C) an underpayment, the corrective payment shall be disregarded in determining the income of the family, and shall be disregarded in determining its resources in the month the corrective payment is made and in the following month;

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[27] P.L. 100-485, §201(a), amended paragraph (19) in its entirety. For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1). [For paragraph (19) as it reads until then, see Vol. III, P.L. 100-485.]

[28] See Vol. II, P.L. 95-608, §§2-113, with respect to Indian child welfare.

except that no recovery need be attempted or carried out under subparagraph (B) in any case, other than a case involving fraud on the part of the recipient, where (as determined by the State agency in accordance with criteria for determining cost-effectiveness, and with dollar limitations, which shall be prescribed by the Secretary in regulations) the cost of recovery would equal or exceed the amount of the overpayment involved;

(23) provide that by July 1, 1969, the amounts used by the State to determine the needs of individuals will have been adjusted to reflect fully changes in living costs since such amounts were established, and any maximums that the State imposes on the amount of aid paid to families will have been proportionately adjusted;

(24) provide that if an individual is receiving benefits under title XVI or his costs in a foster family home or child-care institution are covered by the foster care maintenance payments being made to his or her minor parent as provided in section 475(4)(B), then, for the period for which such benefits are received or such costs are so covered, such individual shall not be regarded as a member of a family for purposes of determining the amount of the benefits of the family under this title and his income and resources shall not be counted as income and resources of a family under this title;

(25) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act;

(26) provide that, as a condition of eligibility for aid, each applicant or recipient will be required—

(A) to assign the State any rights to support from any other person such applicant may have (i) in his own behalf or in behalf of any other family member for whom the applicant is applying for or receiving aid, and (ii) which have accrued at the time such assignment is executed;

(B) to cooperate with the State (i) in establishing the paternity of a child born out of wedlock with respect to whom aid is claimed, and (ii) in obtaining support payments for such applicant and for a child with respect to whom such aid is claimed, or in obtaining any other payments or property due such applicant or such child, unless (in either case) such applicant or recipient is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the child on whose behalf aid is claimed; and that, if the relative with whom a child is living is found to be ineligible because of failure to comply with the requirements of subparagraphs (A) and (B) of this paragraph, any aid for which such child is eligible will be provided in the form of protective payments as described in section 406(b)(2) (without regard to clauses (A) through (D) of such section) unless the State agency, after making reasonable efforts, is unable to locate an appropriate individual to whom such payments can be made; and

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the State's plan for medical assistance under title XIX, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; but the State shall not be subject to any financial penalty in the administration or enforcement of this subparagraph as a result of any monitoring, quality control, or auditing requirements;

(27) provide that the State has in effect a plan approved under part D and operates a child support program in substantial compliance with such plan;

(28) provide that, in determining the amount of aid to which an eligible family is entitled, any portion of the amounts collected in any particular month as child support pursuant to a plan approved under part D, and retained by the State under section 457, which (under the State plan approved under this part as in effect both during July 1975 and during that particular month) would not have caused a reduction in the amount of aid paid to the family if such amounts had been paid directly to the family, shall be added to the amount of aid otherwise payable to such family under the State plan approved under this part;

[(29) Repealed.[29]**]**

(30) at the option of the State, provide for the establishment and operation, in accordance with an (initial and annually updated) advance automated[30] data processing planning document approved under subsection (e)[31], of an automated statewide management information system designed effectively and efficiently, to assist management in the administration of the State plan for aid to families with dependent children approved under this part, so as (A) to control and account for (i) all the factors in the total eligibility determination process under such plan for aid (including but not limited to (I) identifiable correlation factors (such as social security numbers, names, dates of birth, home addresses, and mailing addresses (including postal ZIP codes), of all applicants and recipients of such aid and the relative with whom any child who is such an applicant or recipient is living) to assure sufficient compatibility among the systems of different jurisdictions to permit periodic screening to determine whether an individual is or has been receiving benefits from more than one jurisdiction, (II) checking records of applicants and recipients of such aid on a periodic basis with other agencies, both intra- and inter-State, for determination and verification of eligibility and payment pursuant to requirements imposed by other provisions of this Act), (ii) the costs, quality, and delivery of funds and services furnished to appli-

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[29] P.L. 98-369, §2651(b)(2); 98 Stat. 1149.

[30] P.L. 101-239, §10403(a)(1)(B)(i), struck out "automatic" and substituted "automated", effective as if included in the enactment of P.L. 100-485, §123(d).

[31] P.L. 100-485, §402(c)(2)(B), struck out "(d)" and substituted "(e)", effective October 1, 1989.

cants for and recipients of such aid, (B) to notify the appropriate officials of child support, food stamp, social service, and medical assistance programs approved under title XIX whenever the case becomes ineligible or the amount of aid or services is changed, and (C) to provide for security against unauthorized access to, or use of, the data in such system;

(31) provide that, in making the determination for any month under paragraph (7), the State agency shall take into consideration so much of the income of the dependent child's stepparent living in the same home as such child as exceeds the sum of (A) the first $75 of the total of such stepparent's earned income for such month, (B) the State's standard of need under such plan for a family of the same composition as the stepparent and those other individuals living in the same household as the dependent child and claimed by such stepparent as dependents for purposes of determining his Federal personal income tax liability but whose needs are not taken into account in making the determination under paragraph (7), (C) amounts paid by the stepparent to individuals not living in such household and claimed by him as dependents for purposes of determining his Federal personal income tax liability, and (D) payments by such stepparent of alimony or child support with respect to individuals not living in such household;

(32) provide that no payment of aid shall be made under the plan for any month if the amount of such payment, as determined in accordance with the applicable provisions of the plan and of this part, would be less than $10, but an individual with respect to whom a payment of aid under the plan is denied solely by reason of this paragraph is deemed to be a recipient of aid but shall not be eligible to participate in a community work experience program;

(33) provide that in order for any individual to be considered a dependent child, a caretaker relative whose needs are to be taken into account in making the determination under paragraph (7), or any other person whose needs should be taken into account in making such a determination with respect to the child or relative, such individual must be either (A) a citizen, or (B) an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (including any alien who is lawfully present in the United States as a result of the application of the provisions of section 207(c) of the Immigration and Nationality Act[32] (or of section 203(a)(7) of such Act prior to April 1, 1980), or as a result of the application of the provisions of section 208 or 212(d)(5) of such Act);

(34) provide that both the standard of need applied to a family and the amount of aid determined to be payable, when not a whole dollar amount, shall be rounded to the next lower whole dollar amount;

[(35) Repealed.[33]**]**

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[32] P.L. 82-414.

[33] P.L. 100-485, §202(b)(3); 102 Stat. 2377. For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

(36) provide, at the option of the State, that in making the determination for any month under paragraph (7), the State agency shall not include as income any support or maintenance assistance furnished to or on behalf of the family which (as determined under regulations of the Secretary by such State agency as the chief executive officer of the State may designate) is based on need for such support and maintenance, including assistance received to assist in meeting the costs of home energy (including both heating and cooling), and which is (A) assistance furnished in kind by a private nonprofit agency, or (B) assistance furnished by a supplier of home heating oil or gas, by an entity whose revenues are primarily derived on a rate-of-return basis regulated by a State or Federal governmental entity, or by a municipal utility providing home energy;

(37) provide that if any family becomes ineligible to receive aid to families with dependent children because of hours of or income from employment of the caretaker relative or because of paragraph (8)(B)(ii)(II), having received such aid in at least 3 of the 6 months immediately preceding the month in which such ineligibility begins, the family shall remain eligible for medical assistance under the State's plan approved under title XIX for an extended period or periods as provided in section 1925, and that the family will be appropriately notified of such extension (in the State agency's notice to the family of the termination of its eligibility for such aid) as required by section 1925(a)(2);[34]

(38) provide that in making the determination under paragraph (7) with respect to a dependent child and applying paragraph (8), the State agency shall (except as otherwise provided in this part) include—

(A) any parent of such child, and

(B) any brother or sister of such child, if such brother or sister meets the conditions described in clauses (1) and (2) of section 406(a) or in section 407(a)[35],

if such parent, brother, or sister is living in the same home as the dependent child, and any income of or available for such parent, brother, or sister shall be included in making such determination and applying such paragraph with respect to the family (notwithstanding section 205(j), in the case of benefits provided under title II);

(39) provide that in making the determination under paragraph (7) with respect to a dependent child whose parent[36] is under the age of 18, the State agency shall (except as otherwise provided in this part) include any income of such minor's own parents[37] who are living in the same home as such minor and

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[34] P.L. 100-485, §303(b)(3), amended paragraph (37) in its entirety, effective April 1, 1990. P.L. 101-239, §6411(i)(2), provides that such amendment shall not apply with respect to families that cease to be eligible for aid under part A of this title, before April 1, 1990. Effective September 30, 1998, this paragraph (37) is repealed and the paragraph (37), as in effect immediately before April 1, 1990, shall become effective on September 30, 1998. [For paragraph (37) as it reads until April 1, 1990, see Vol. III, P.L. 100-485.]

[35] P.L. 100-485, §401(a)(2)(A), struck out "(if such section is applicable to the State)", effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

[36] P.L. 101-508, §5053(a)(1), struck out "or legal guardian", effective November 5, 1990.

[37] P.L. 101-508, §5053(a)(2), struck out "or legal guardians", effective November 5, 1990.

dependent child, to the same extent that income of a stepparent is included under paragraph (31);

(40) provide, if the State has elected to establish and operate a fraud control program under section 416, that the State will submit to the Secretary (with such revisions as may from time to time be necessary) a description of and budget for such program, and will operate such program in full compliance with that section;

(41) provide that aid to families with dependent children will be provided under the plan with respect to dependent children of unemployed parents in accordance with section 407;[38]

(42) provide that if, under section 407(b)(2)(B)(i), the State limits the number of months for which a family may receive aid to families with dependent children, the State shall provide medical assistance to all members of the family under the State's plan approved under title XIX, without time limitation;[39]

(43) at the option of the State, provide that—

(A) subject to subparagraph (B), in the case of any individual who is under the age of 18 and has never married, and who has a dependent child in his or her care (or is pregnant and is eligible for aid to families with dependent children under the State plan)—

(i) such individual may receive aid to families with dependent children under the plan for the individual and such child (or for herself in the case of a pregnant woman) only if such individual and child (or such pregnant woman) reside in a place of residence maintained by a parent, legal guardian, or other adult relative of such individual as such parent's, guardian's, or adult relative's own home, or reside in a foster home, maternity home, or other adult-supervised supportive living arrangement; and

(ii) such aid (where possible) shall be provided to the parent, legal guardian, or other adult relative on behalf of such individual and child; and

(B) subparagraph (A) does not apply in the case where—

(i) such individual has no parent or legal guardian of his or her own who is living and whose whereabouts are known;

(ii) no living parent or legal guardian of such individual allows the individual to live in the home of such parent or guardian;

(iii) the State agency determines that the physical or emotional health or safety of such individual or such dependent child would be jeopardized if such individual and such dependent child lived in the same residence with such individual's own parent or legal guardian;

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[38] P.L. 100-485, §401(a)(1)(C), added paragraph (41), effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

[39] P.L. 100-485, §401(f)(3), added paragraph (42), effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

(iv) such individual lived apart from his or her own parent or legal guardian for a period of at least one year before either the birth of any such dependent child or the individual having made application for aid to families with dependent children under the plan; or

(v) the State agency otherwise determines (in accordance with regulations issued by the Secretary) that there is good cause for waiving such subparagraph;[40]

(44) provide that the State agency shall—

(A) be responsible for assuring that the benefits and services under the programs under this part, part D, and part F are furnished in an integrated manner, and

(B) consistent with the provisions of this title, ensure that all applicants for and recipients of aid to families with dependent children are encouraged, assisted, and required to cooperate in the establishment of paternity and the enforcement of child support obligations, and are notified of the paternity establishment and child support services for which they may be eligible; and[41]

(45) provide (in accordance with regulations issued by the Secretary) for appropriate measures to detect fraudulent applications for aid to families with dependent children prior to the establishment of eligibility for such aid.[42]

The Secretary may waive any of the requirements imposed under or in connection with paragraphs (13) and (14) of this subsection to the extent necessary to make such requirements compatible with the corresponding reporting and budgeting requirements by the Food Stamp Act of 1977[43]. [44]

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes as a condition of eligibility for aid to families with dependent children, a residence requirement which denies aid with respect to any child residing in the State (1) who has resided in the State for one year immediately preceding the application for such aid, or (2) who was born within one year immediately preceding the application, if the parent or other relative with whom the child is living has resided in the State for one year immediately preceding the birth.

(c) The Secretary shall, on the basis of his review of the reports received from the States under paragraph (15) of subsection (a), compile such data as he believes necessary and from time to time publish his findings as to the effectiveness of the programs developed and administered by the States under such paragraph. The Secretary shall annually report to the Congress (with the first such report being made on or before July 1, 1970) on the programs developed and administered by each State under such paragraph (15).

[(d) Repealed.[45]**]**

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[40] P.L. 100-485, §403(a)(3), added paragraph (43), effective January 1, 1990.

[41] P.L. 100-485, §604(a)(3), added paragraph (44), effective July 1, 1989.

[42] P.L. 100-485, §605(a)(3), added paragraph (45), effective October 1, 1989.

[43] P.L. 88-525.

[44] See Vol. II, P.L. 99-514, §1883(b)(11), with respect to the effect of the failure of a State to comply with certain provisions or the imposition by a State of a requirement inconsistent with certain provisions.

[45] P.L. 100-485, §402(c)(2)(A); repealed subsection (d), effective October 1, 1989. **[**For subsection (d) as it reads until then, see Vol. III, P.L. 100-485.**]**

(e)(1) The Secretary shall not approve the initial and annually updated advance automated data processing planning document, referred to in subsection (a)(30), unless he finds that such document, when implemented, will generally carry out the objectives of the statewide management system referred to in such subsection, and such document—

(A) provides for the conduct of, and reflects the results of, requirements analysis studies, which include consideration of the program mission, functions, organization, services, constraints, and current support, of, in, or relating to, such system,

(B) contains a description of the proposed statewide management system, including a description of information flows, input data, and output reports and uses,

(C) sets forth the security and interface requirements to be employed in such statewide management system,

(D) describes the projected resource requirements for staff and other needs, and the resources available or expected to be available to meet such requirements,

(E) includes cost-benefit analyses of each alternative management system, data processing services and equipment, and a cost allocation plan containing the basis for rates, both direct and indirect, to be in effect under such statewide management system,

(F) contains an implementation plan with charts of development events, testing descriptions, proposed acceptance criteria, and backup and fallback procedures to handle possible failure of contingencies, and

(G) contains a summary of proposed improvement of such statewide management system in terms of qualitative and quantitative benefits.

(2)(A) The Secretary shall, on a continuing basis, review, assess, and inspect the planning, design, and operation of, statewide management information systems referred to in section 403(a)(3)(B), with a view to determining whether, and to what extent, such systems meet and continue to meet requirements imposed under such section and the conditions specified under subsection (a)(30) of this section.

(B) If the Secretary finds with respect to any statewide management information system referred to in section 403(a)(3)(B) that there is a failure substantially to comply with criteria, requirements, and other undertakings, prescribed by the advance automated data processing planning document theretofore approved by the Secretary with respect to such system, then the Secretary shall suspend his approval of such document until there is no longer any such failure of such system to comply with such criteria, requirements, and other undertakings so prescribed.

(C) If the Secretary determines that such a system has not been implemented by the State by the date specified for implementation in the State's advance automated data processing planning document, then the Secretary shall reduce payments to such State, in accordance with section 403(b), in an amount equal to 40 percent of the expenditures referred to in section 403(a)(3)(B) with respect to which payments were made to the State under section 403(a)(3)(B). The Secretary may extend the deadline for implementation if the State demonstrates to the satisfaction of the Secretary that the State cannot implement such system by the date specified in such planning document due to circumstances beyond the State's control.

(f)(1) For temporary disqualification of certain newly legalized aliens from receiving aid to families with dependent children, see subsection (h) of section 245A of the Immigration and Nationality Act[46], subsection (f) of section 210 of such Act, and subsection (d)(7) of section 210A of such Act.

(2) In any case where an alien disqualified from receiving aid under such subsection (h), (f), or (d)(7) is the parent of a child who is not so disqualified and who (without any adjustment of status under such section 245A, 210, or 210A) is considered a dependent child under subsection (a)(33), or is the brother or sister of such a child, subsection (a)(38) shall not apply, and the needs of such alien shall not be taken into account in making the determination under subsection (a)(7) with respect to such child, but the income of such alien (if he or she is the parent of such child) shall be included in making such determination to the same extent that income of a stepparent is included under subsection (a)(31).

(g)(1)(A)(i)[47] Each State agency must guarantee child care in accordance with subparagraph (B)—

(I)[48] for each family with a dependent child requiring such care, to the extent that such care is determined by the State agency to be necessary for an individual in the family to accept employment or remain employed; and

(II)[49] for each individual participating in an education and training activity (including participation in a program that meets the requirements of subsection (a)(19) and part F) if the State agency approves the activity and determines that the individual is satisfactorily participating in the activity.

(ii) Each State agency must guarantee child care, subject to the limitations described in this section, to the extent that such care is determined by the State agency to be necessary for an individual's employment in any case where a family has ceased to receive aid to families with dependent children as a result of increased hours of, or increased income from, such employment or by reason of subsection (a)(8)(B)(ii)(II).[50]

(iii) A family shall only be eligible for child care provided under clause (ii) for a period of 12 months after the last month for which the family received aid to families with dependent children under this part.[51]

(iv) A family shall not be eligible for child care provided under clause (ii) unless the family received aid to families with dependent[52] children in at least 3 of the 6 months immediately preceding the month in which the family became ineligible for such aid.[53]

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[46] P.L. 82-414.

[47] P.L. 100-485, §302(a)(1), inserted "(i)", effective April 1, 1990, but such amendment is repealed effective September 30. 1998.

[48] P.L. 100-485, §302(a)(2), redesignated clause (i) as subclause (I), effective April 1, 1990, but such amendment is repealed effective September 30, 1998.

[49] P.L. 100-485, §302(a)(2), redesignated clause (ii) as subclause (II), effective April 1, 1990, but such amendment is repealed effective September 30, 1998.

[50] P.L. 100-485, §302(a)(3), added this clause (ii), effective April 1, 1990, but such amendment is repealed effective September 30, 1998.

[51] P.L. 100-485, §302(c), added this clause, effective April 1, 1990, but such amendment is repealed effective September 30, 1998.

[52] P.L.101-239, §10403(a)(1)(C)(i)(I), struck out "includes a child who is (or, if needy," and substituted "received aid to families with dependent", effective as if included in the enactment of P.L. 101-485.

(v) A family shall not be eligible for child care provided under clause (ii) unless the family includes a child who is[54] (or, if needy, would be) a dependent child.[55]

(vi) A family shall not be eligible for child care provided under clause (ii) for any month beginning after the caretaker relative who is a member of the family has—

(I) without good cause, terminated his or her employment; or

(II) refused to cooperate with the State in establishing and enforcing his or her child support obligations, without good cause as determined by the State agency in accordance with standards prescribed by the Secretary which shall take into consideration the best interests of the child for whom child care is to be provided.[56] [57]

(vii) A family shall contribute to child care provided under clause (ii) in accordance with a sliding scale formula which shall be established by the State agency based on the family's ability to pay.[58]

(B) The State agency may guarantee child care by—

(i) providing such care directly;

(ii) arranging the care through providers by use of purchase of service contracts, or vouchers;

(iii) providing cash or vouchers in advance to the caretaker relative in the family;

(iv) reimbursing the caretaker relative in the family; or

(v) adopting such other arrangements as the agency deems appropriate.

When the State agency arranges for child care, the agency shall take into account the individual needs of the child.

(C)(i) Subject to clause (ii), the State agency shall make payment for the cost of child care provided with respect to a family in an amount that is the lesser of—

(I) the actual cost of such care; and

(II) the dollar amount of the child care disregard for which the family is otherwise eligible under subsection (a)(8)(A)(iii), or (if higher) an amount established by the State.

(ii) The State agency may not reimburse the cost of child care provided with respect to a family in an amount that is greater than the applicable local market rate (as determined by the State in accordance with regulations issued by the Secretary).

(D) The State may not make any change in its method of reimbursing child care costs which has the effect of disadvantaging families receiving aid under the State plan on the date of the enactment of this section[59], by reducing their income or otherwise.

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[53] P.L. 100-485, §302(c), added this clause, effective April 1, 1990, but such amendment is repealed effective September 30, 1998.

[54] P.L.101-239, §10403(a)(1)(C)(i)(II), struck out a comma.

[55] P.L. 100-485, §302(c), added this clause, effective April 1, 1990, but such amendment is repealed effective September 30, 1998.

[56] P.L. 101-508, §5060(a), amended subclause (II) in its entirety, effective November 5, 1990. Margin as in original. Until November 5, 1990, subclause (II) reads as follows:

"(II) failed to cooperate with the State in establishing and enforcing his or her child support obligations.".

[57] P.L. 100-485, §302(c), added this clause, effective April 1, 1990, but such amendment is repealed effective September 30, 1998.

[58] P.L. 100-485, §302(c), added this clause, effective April 1, 1990, but such amendment is repealed effective September 30, 1998.

See Vol. II, P.L. 100-485, §302(d), with respect to a study of welfare requalification and regulations based on results of such study.

[59] Probably should be "subsection". This subsection was enacted on October 13, 1988. [P.L 100-485, 102 Stat. 2382].

(E) The value of any child care provided or arranged (or any amount received as payment for such care or reimbursement for costs incurred for the care) under this paragraph—

(i) shall not be treated as income for purposes of any other Federal or federally-assisted program that bases eligibility for or the amount of benefits upon need, and

(ii) may not be claimed as an employment-related expense for purposes of the credit under section 21 of the Internal Revenue Code of 1986.

(2) In the case of any individual participating in the program under part F, each State agency (in addition to guaranteeing child care under paragraph (1)) shall provide payment or reimbursement for such transportation and other work-related expenses (including other work-related supportive services), as the State determines are necessary to enable such individual to participate in such program.

(3)(A)(i)[60] In the case of amounts expended for child care pursuant to paragraph (1)(A) by any State to which section 1108 does not apply, the applicable rate for purposes of section 403(a) shall be the Federal medical assistance percentage (as defined in section 1905(b)).

(ii) In the case of amounts expended for child care pursuant to paragraph (1)(A)(ii) (relating to the provision of child care for certain families which cease to receive aid under this part) by any State to which section 1108 applies, the applicable rate for purposes of section 403(a) shall be the Federal medical assistance percentage (as defined in section 1118).[61]

(B) In the case of any amounts expended by the State agency for child care under this subsection, only such amounts as are within such limits as the State may prescribe (subject to the limitations of paragraph (1)(C)) shall be treated as amounts for which payment may be made to a State under this part and they may be so treated only to the extent that—

(i) such amounts do not exceed the applicable local market rate (as determined by the State in accordance with regulations issued by the Secretary);

(ii) the child care involved meets applicable standards of State and local law; and

(iii) in the case of child care, the entity providing such care allows parental access.

(4) The State must establish procedures to ensure that center-based child care will be subject to State and local requirements designed to ensure basic health and safety, including fire safety, protections. The State must also endeavor to develop guidelines for family day care. The State must provide the Secretary with a description of such State and local requirements and guidelines.

(5) By October 1, 1992, the Secretary shall report to the Congress on the nature and content of State and local standards for health and safety.

(6)(A) The Secretary shall make grants to States to improve their child care licensing and registration requirements and procedures, to enforce standards with respect to child care provided to children under this part, and to provide for the training of child care providers[62].

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[60] P.L. 100-485, §302(b)(1)(A), inserted "(i)", effective April 1, 1990, but such amendment is repealed effective September 30, 1998.

[61] P.L. 100-485, §302(b)(1)(B), added clause (ii), effective April 1, 1990, but such amendment is repealed effective September 30, 1998.

(B) Subject to subparagraph (C), the Secretary shall make grants to each State under subparagraph (A) in proportion to the number of children in the State receiving aid under the State plan approved under subsection (a).

(C) The Secretary may not make grants to a State under subparagraph (A) unless the State provides matching funds in an amount that is not less than 10 percent of the amount of the grant.

(D) For grants under this paragraph, there is authorized to be appropriated to the Secretary $13,000,000 for each of the fiscal years 1990 and 1991, and $50,000,000 for each of fiscal years 1992, 1993, and 1994[63].

(E) Each State to which the Secretary makes a grant under this paragraph shall expend not less than 50 percent of the amount of the grant to provide for the training of child care providers.[64]

(7) Activities under this subsection and subsection (i)[65] shall be coordinated in each State with existing early childhood education programs in that State, including Head Start programs, preschool programs funded under chapter 1 of the Education Consolidation and Improvement Act of 1981[66], and school and nonprofit child care programs (including community-based organizations receiving funds designated for preschool programs for handicapped children).[67]

(h)(1) Each State shall reevaluate the need standard and payment standard under its plan at least once every 3 years, in accordance with a schedule established by the Secretary, and report the results of the reevaluation to the Secretary and the public at such time and in such form and manner as the Secretary may require.

(2) The report required by paragraph (1) shall include a statement of—

(A) the manner in which the need standard of the State is determined,

(B) the relationship between the need standard and the payment standard (expressed as a percentage or in any other manner determined by the Secretary to be appropriate), and

(C) any changes in the need standard or the payment standard in the preceding 3-year period.

(3) The Secretary shall report promptly to the Congress the results of the reevaluations required by paragraph (1).

(i)(1) Each State agency may, to the extent that it determines that resources are available, provide child care in accordance with paragraph (2) to any low income family that the State determines—

(A) is not receiving aid under the State plan approved under this part;

(B) needs such care in order to work; and

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[62] P.L. 101-508, §5081(c)(2), struck out "and to monitor child care provided to children receiving aid under the State plan approved under subsection (a)" and substituted "to enforce standards with respect to child care provided to children under this part, and to provide for the training of child care providers", effective October 1, 1990.

[63] P.L. 101-508, §5081(c)(1), inserted ", and $50,000,000 for each of fiscal years 1992, 1993, and 1994", effective October 1, 1990.

[64] P.L. 101-508, §5081(c)(3), added subparagraph (E), effective October 1, 1990.

[65] P.L. 101-508, §5081(d), inserted "and subsection (i)", effective October 1, 1990.

[66] P.L. 97-35, Title V, Subtitle D.

P.L. 100-297, §1003(a), repealed Subtitle D.

[67] P.L. 100-485, §301, added subsection (g), effective with respect to a State on the date the amendments made by title II of P.L. 100-485 become effective with respect to the State. For the effective date of title II of P.L. 100-485, see Vol. II, P.L. 100-485, §204.

(C) would be at risk of becoming eligible for aid under the State plan approved under this part if such care were not provided.

(2) The State agency may provide child care pursuant to paragraph (1) by—

(A) providing such care directly;

(B) arranging such care through providers by use of purchase of service contracts or vouchers;

(C) providing cash or vouchers in advance to the family;

(D) reimbursing the family; or

(E) adopting such other arrangements as the agency deems appropriate.

(3)(A) A family provided with child care under paragraph (1) shall contribute to such care in accordance with a sliding scale formula established by the State agency based on the family's ability to pay.

(B) The State agency shall make payment for the cost of child care provided under paragraph (1) with respect to a family in an amount that is the lesser of—

(i) the actual cost of such care; and

(ii) the applicable local market rate (as determined by the State in accordance with regulations issued by the Secretary).

(4) The value of any child care provided or arranged (or any amount received as payment for such care or reimbursement for costs incurred for the care) under this subsection—

(A) shall not be treated as income or as a deductible expense for purposes of any other Federal or federally assisted program that bases eligibility for or amount of benefits upon need; and

(B) may not be claimed as an employment-related expense for purposes of the credit under section 21 of the Internal Revenue Code of 1986.

(5) Amounts expended by the State agency for child care under paragraph (1) shall be treated as amounts for which payment may be made to a State under section 403(n) only to the extent that—

(A) such amounts are paid in accordance with paragraph (3)(B);

(B) the care involved meets applicable standards of State and local law;

(C) the provider of the care—

(i) in the case of a provider who is not an individual that provides such care solely to members of the family of the individual, is licensed, regulated, or registered by the State or locality in which the care is provided; and

(ii) allows parental access; and

(D) such amounts are not used to supplant any other Federal or State funds used for child care services.

(6)(A)(i) Each State shall prepare reports annually, beginning with fiscal year 1993, on the activities of the State carried out with funds made available under section 403(n).

(ii) The State shall make available for public inspection within the State copies of each report required by this paragraph, shall transmit a copy of each such report to the Secretary, and shall provide a copy of each such report, on request, to any interested public agency.

(iii) The Secretary shall annually compile, and submit to the Congress, the State reports transmitted to the Secretary pursuant to clause (ii).

(B) Each report prepared and transmitted by a State under subparagraph (A) shall set forth with respect to child care services provided under this subsection—

(i) showing separately for center-based child care services, group home child care services, family child care services, and relative care services, the number of children who received such services and the average cost of such services;

(ii) the criteria applied in determining eligibility or priority for receiving services, and sliding fee schedules;

(iii) the child care licensing and regulatory (including registration) requirements in effect in the State with respect to each type of service specified in clause (i); and

(iv) the enforcement policies and practices in effect in the State which apply to licensed and regulated child care providers (including providers required to register).

(C) Within 12 months after the date of the enactment of this subsection, the Secretary shall establish uniform reporting requirements for use by the States in preparing the information required by this paragraph, and make such other provision as may be necessary or appropriate to ensure that compliance with this subsection will not be unduly burdensome on the States.

(D) Not later than July 1, 1992, the Secretary shall issue a report on the implementation of this subsection, based on such information as as has[68] been made available to the Secretary by the States.[69]

PAYMENT TO STATES[70]

SEC. 403. [42 U.S.C. 603] (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid and services to needy families with children, for each quarter, beginning with the quarter commencing October 1, 1958—

(1) in the case of any State other than Puerto Rico, the Virgin Islands, Guam, and American Samoa, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as aid to families with dependent children under the State plan—

(A) five-sixths of such expenditures, not counting so much of any expenditure with respect to any month as exceeds the product of $18 multiplied by the total number of recipients of aid to families with dependent children for such month (which total number, for purposes of this subsection, means (i) the number of individuals with respect to whom such aid in the form of money payments is paid for such month, plus (ii) the number of individuals, not counted under clause (i), with respect to whom payments described in section 406(b)(2) are made in such month and included as expenditures for purposes of this paragraph or paragraph (2)); plus

(B) the Federal percentage of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds (i) the product of $32 multiplied by the total number of recipients of aid to families with dependent children (other than such aid in the form of foster care) for such month, plus (ii) the product of $100 multiplied by the total number of recipients of aid to families with dependent children in the form of foster care for such month; and

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[68] As in original. Probably should be "information as has".

[69] P.L. 101-508, §5081(a), added subsection (i), effective October 1, 1990.

[70] See Vol. II, P.L. 73-30, §§1-15, with respect to the United States Employment Service.

See Vol. II, P.L. 94-566, §508(b), with respect to provision for reimbursement of expenses of State employment offices.

(2) in the case of Puerto Rico, the Virgin Islands, Guam, and American Samoa, an amount equal to one-half of the total of the sums expended during such quarter as aid to families with dependent children under the State plan, not counting so much of any expenditure with respect to any month as exceeds $18 multiplied by the total number of recipients of such aid for such month; and[71]

(3) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan—

(A) 100 percent of so much of such expenditures as are for the costs of the implementation and operation of the immigration status verification system described in section 1137(d),

(B) 90 per centum of so much of the sums expended during such quarter as are attributable to the planning, design, development, or installation of such statewide mechanized claims processing and information retrieval systems as (i) meet the conditions of section 402(a)(30), and (ii) the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of State plans approved under title XIX, and State programs with respect to which there is Federal financial participation under title XX,

(C) 75 percent of so much of such expenditures as are for the costs of carrying out a fraud control program under section 416, including costs related to the investigation, prosecution, and administrative hearing of fraudulent cases and the making of any resultant collections, and

(D) one-half of the remainder of such expenditures (including any amounts expended by the State to carry out initial evaluations under section 486(a))[72]; and[73]

except that no payment shall be made with respect to amounts expended in connection with the provision of any service described in section 2002(a) of this Act other than services furnished pursuant to section 402(g)[74]; and

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[71] See §§1108 and 1118 of Social Security Act.

[72] P.L. 100-485, §201(d), inserted "(including any amounts expended by the State to carry out initial evaluations under section 486(a))". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

[73] P.L. 100-485, §202(b)(4)(A), struck out "(including as expenditures under this subparagraph the value of any services furnished, and the amount of any payments made (to cover expenses incurred by individuals under a program of employment search), under section 402(a)(35)(B))," and substituted "; and". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

[(4) Repealed.[75]]

(5) in the case of any State, an amount equal to 50 per centum of the total amount expended under the State plan during such quarter as emergency assistance to needy families with children.

No payment shall be made under this subsection with respect to amounts paid to supplement or otherwise increase the amount of aid to families with dependent children found payable in accordance with section 402(a)(13) if such amount is determined to have been paid by the State in recognition of the current or anticipated needs of a family (other than with respect to the first or first and second months of eligibility), but any such amount, if determined to have been paid by the State in recognition of the difference between the current or anticipated needs of a family for a month based upon actual income or other relevant circumstances for such month, and the needs of such family for such month based upon income and other relevant circumstances as retrospectively determined under section 402(a)(13)(A)(ii), shall not be considered income within the meaning of section 402(a)(13) for the purpose of determining the amount of aid in the succeeding months.[76]

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of dependent children in the State, and (C) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary, (A) reduced or increased, as the case may be, by any sum by which he finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such

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[74] P.L. 100-485, §202(b)(4)(B), struck out "under section 402(a)(35)(B) (as described in the parenthetical phrase in subparagraph (D)), and other than services the provision of which is required by section 402(a)(19) to be included in the plan of the State, or which is a service provided in connection with a community work experience program or work supplementation program under section 409 or 414" and substituted "pursuant to section 402(g)". For the effective date, see Vol. II, P.L.-100-485, §204(a) and (b)(1).

[75] P.L. 90-248, §201(e)(3); 81 Stat. 880.

[76] See Vol. II, P.L. 81-474, §9, with respect to additional payments with respect to Navajo and Hopi Indians.

See Vol. II, P.L. 93-288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 94-566, §508(b), with respect to expenses of State employment offices.

See Vol. II, P.L. 100-139, §4(h)(6), with respect to exclusion of benefits as basis for denial of eligibility.

See Vol. II, P.L. 100-407, §105(c), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100-409, §5, with respect to the effect of this Act on P.L. 92-203 or P.L. 96-487.

See Vol. II, P.L. 100-411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100-581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

quarter, (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any prior quarter by the State or any political subdivision thereof with respect to aid to families with dependent children furnished under the State plan, and (C) reduced by such amount as is necessary to provide the "appropriate reimbursement of the Federal Government" that the State is required to make under section 457 out of that portion of child support collections retained by it pursuant to such section; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary for such prior quarter.

(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Department of the Treasury and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary, the amount so certified.

[(c) Repealed.[77]**]**

[(d) Repealed.[78]**]**

(e) In order to assist in obtaining the information needed to carry out subsection (b)(1) and otherwise to perform his duties under this part, the Secretary shall establish uniform reporting requirements under which each State will be required periodically to furnish such information and data as the Secretary may determine to be necessary to ensure that sections 402(a)(37), 402(a)(43), and 402(g)(1)(A), are being effectively implemented, including at a minimum the average monthly number of families assisted under each such section, the types of such families, the amounts expended with respect to such families, and the length of time for which such families are assisted. The information and data so furnished with respect to families assisted under section 402(g) shall be separately stated with respect to families who have earnings and those who do not, and with respect to families who are receiving aid under the State plan and those who are not.

(f) Notwithstanding any other provision of this section, the amount payable to any State under this part for quarters in a fiscal year shall with respect to quarters in fiscal years beginning after June 30, 1973, be reduced by 1 per centum (calculated without regard to any reduction under section 403(g)) of such amount if such State—

(1) in the immediately preceding fiscal year failed to carry out the provisions of section 402(a)(15)(B) as pertain to requiring the offering and arrangement for provision of family planning services; or

(2) in the immediately preceding fiscal year (but, in the case of the fiscal year beginning July 1, 1972, only considering the third and fourth quarters thereof), failed to carry out the provisions of section 402(a)(15)(B) of the Social Security Act with respect to any individual who, within such period or periods as the Secre-

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[77] P.L. 100-485, §202(b)(5), repealed subsection (c). For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1). **[**For subsection (c) as it reads until then, see Vol. III, P.L. 100-485.**]**

[78] P.L. 100-485, §202(b)(6), repealed subsection (d). For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1). **[**For subsection (d) as it reads until then, see Vol. III, P.L. 100-485.**]**

tary may prescribe, has been an applicant for or recipient of aid to families with dependent children under the plan of the State approved under this part.

[(g) Repealed.[79]]

(h)(1) Notwithstanding any other provision of this Act, if a State's program operated under part D is found as a result of a review conducted under section 452(a)(4) not to have complied substantially with the requirements of such part for any quarter beginning after September 30, 1983, and the Secretary determines that the State's program is not complying substantially with such requirements at the time such finding is made, the amounts otherwise payable to the State under this part for such quarter and each subsequent quarter, prior to the first quarter throughout which the State program is found to be in substantial compliance with such requirements, shall be reduced (subject to paragraph (2)) by—

(A) not less than one nor more than two percent, or

(B) not less than two nor more than three percent, if the finding is the second consecutive such finding made as a result of such a review, or

(C) not less than three nor more than five percent, if the finding is the third or a subsequent consecutive such finding made as a result of such a review.

(2)(A) The reductions required under paragraph (1) shall be suspended for any quarter if—

(i) the State submits a corrective action plan, within a period prescribed by the Secretary following notice of the finding under paragraph (1), which contains steps necessary to achieve substantial compliance within a time period which the Secretary finds to be appropriate;

(ii) the Secretary approves such corrective action plan (and any amendments thereto) as being sufficient to achieve substantial compliance; and

(iii) the Secretary finds that the corrective action plan (and any amendment thereto approved by the Secretary under clause (ii)), is being fully implemented by the State and that the State is progressing in accordance with the timetable contained in the plan to achieve substantial compliance with such requirements.

(B) A suspension of the penalty under subparagraph (A) shall continue until such time as the Secretary determines that—

(i) the State has achieved substantial compliance,

(ii) the State is no longer implementing its corrective action plan, or

(iii) the State is implementing or has implemented its corrective action plan but has failed to achieve substantial compliance within the appropriate time period (as specified in subparagraph (A)(i)).

(C)(i) In the case of a State whose penalty suspension ends pursuant to subparagraph (B)(i), the penalty shall not be applied.

(ii) In the case of a State whose penalty suspension ends pursuant to subparagraph (B)(ii), the penalty shall be applied as if the suspension had not occurred.

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[79] P.L. 97-35, §2181(a)(1); 95 Stat. 815.
P.L. 97-248, §137(a)(4); 96 Stat. 376.

(iii) In the case of a State whose penalty suspension ends pursuant to subparagraph (B)(iii), the penalty shall be applied to all quarters ending after the expiration of the time period specified in such subparagraph (and prior to the first quarter throughout which the State program is found to be in substantial compliance).

(3) For purposes of this subsection, section 402(a)(27), and section 452(a)(4), a State which is not in full compliance with the requirements of this part shall be determined to be in substantial compliance with such requirements only if the Secretary determines that any noncompliance with such requirements is of a technical nature which does not adversely affect the performance of the child support enforcement program.

[(i) Repealed.[80]]

[(j) Repealed.[81]]

(k)(1) Each State with a plan approved under part F shall be entitled to payments under subsection (l) for any fiscal year in an amount equal to the sum of the applicable percentages (specified in such subsection) of its expenditures to carry out the program under part F (subject to limitations prescribed by or pursuant to such part or this section on expenditures that may be included for purposes of determining payment under subsection (l)), but such payments for any fiscal year in the case of any State may not exceed the limitation determined under paragraph (2) with respect to the State.

(2) The limitation determined under this paragraph with respect to a State for any fiscal year is—

(A) the amount allotted to the State for fiscal year 1987 under part C of this title as then in effect, plus

(B) the amount that bears the same ratio to the amount specified in paragraph (3) for such fiscal year as the average monthly number of adult recipients (as defined in paragraph (4)) in the State in the preceding fiscal year bears to the average monthly number of such recipients in all the States for such preceding year.

(3) The amount specified in this paragraph is—

(A) $600,000,000 in the case of the fiscal year 1989,

(B) $800,000,000 in the case of the fiscal year 1990,

(C) $1,000,000,000 in the case of each of the fiscal years 1991, 1992, and 1993,

(D) $1,100,000,000 in the case of the fiscal year 1994,

(E) $1,300,000,000 in the case of the fiscal year 1995, and

(F) $1,000,000,000 in the case of the fiscal year 1996 and each succeeding fiscal year,

reduced by the aggregate amount allotted to all the States for fiscal year 1987 pursuant to part C of this title as then in effect.

(4) For purposes of this subsection, the term "adult recipient" in the case of any State means an individual other than a dependent child (unless such child is the custodial parent of another dependent child) whose needs are met (in whole or in part) with payments of aid to families with dependent children.

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[80] P.L. 101-239, §8004(b), repealed subsection (i), effective October 1, 1990. [For subsection (i) as it reads until October 1, 1990, see Vol. III, P.L. 101-239.]

P.L. 101-239, §8004(d), provides that no disallowance or other similar sanction shall be applied to a State for any fiscal year before fiscal year 1991 under subsection (i) or any predecessor statutory or regulatory provision relating to disallowances for erroneous payments made in carrying out a State plan approved under part A of this title.

[81] P.L. 101-239, §8004(b), repealed subsection (j), effective October 1, 1990. [For subsection (j) as it reads until October 1, 1990, see Vol. III, P.L. 101-239.]

(5) None of the funds available to a State for purposes of the programs or activities conducted under part F shall be used for construction.[82]

(l)(1)(A) In lieu of any payment under subsection (a), the Secretary shall pay to each State with a plan approved under section 482(a) (subject to the limitation determined under section 482(i)(2)) with respect to expenditures by the State to carry out a program under part F (including expenditures for child care under section 402(g)(1)(A)(i)[83], but only in the case of a State with respect to which section 1108 applies), an amount equal to—

(i) with respect to so much of such expenditures in a fiscal year as do not exceed the State's expenditures in the fiscal year 1987 with respect to which payments were made to such State from its allotment for such fiscal year pursuant to part C of this title as then in effect, 90 percent; and

(ii) with respect to so much of such expenditures in a fiscal year as exceed the amount described in clause (i)—

(I) 50 percent, in the case of expenditures for administrative costs made by a State in operating such a program for such fiscal year (other than the personnel costs for staff employed full-time in the operation of such program) and the costs of transportation and other work-related supportive services under section 402(g)(2), and

(II) the greater of 60 percent or the Federal medical assistance percentage (as defined in section 1118 in the case of any State to which section 1108 applies, or as defined in section 1905(b) in the case of any other State), in the case of expenditures made by a State in operating such a program for such fiscal year (other than for costs described in subclause (I)).

(B) With respect to the amount for which payment is made to a State under subparagraph (A)(i), the State's expenditures for the costs of operating a program established under part F may be in cash or in kind, fairly evaluated.

(2)(A) Notwithstanding paragraph (1), the Secretary shall pay to a State an amount equal to 50 percent of the expenditures made by such State in operating its program established under part F (in lieu of any different percentage specified in paragraph (1)(A)) if less than 55 percent of such expenditures are made with respect to individuals who are described in subparagraph (B).

(B) An individual is described in this paragraph if the individual—

(i)(I) is receiving aid to families with dependent children, and

(II) has received such aid for any 36 of the preceding 60 months;

(ii)(I) makes application for aid to families with dependent children, and

(II) has received such aid for any 36 of the 60 months immediately preceding the most recent month for which application has been made;

(iii) is a custodial parent under the age of 24 who (I) has not completed a high school education and, at the time of application for aid to families with dependent children, is not enrolled in high school (or a high school equivalency course of instruction), or (II) had little or no work experience in the preceding year; or

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[82] P.L. 100-485, §201(c)(1), added subsection (k). For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

[83] P.L. 100-485, §302(b)(2), inserted "(i)".

(iv) is a member of a family in which the youngest child is within 2 years of being ineligible for aid to families with dependent children because of age.

(C) This paragraph may be waived by the Secretary with respect to any State which demonstrates to the satisfaction of the Secretary that the characteristics of the caseload in that State make it infeasible to meet the requirements of this paragraph, and that the State is targeting other long-term or potential long-term recipients.

(D) The Secretary shall biennially submit to the Congress any recommendations for modifications or additions to the groups of individuals described in subparagraph (B) that the Secretary determines would further the goal of assisting long-term or potential long-term recipients of aid to families with dependent children to achieve self-sufficiency, which recommendations shall take into account the particular characteristics of the populations of individual States.

(3)(A) Notwithstanding paragraph (1), the Secretary shall pay to a State an amount equal to 50 percent of the expenditures made by such State in a fiscal year in operating its program established under part F (in lieu of any different percentage specified in paragraph (1)(A)) if the State's participation rate (determined under subparagraph (B)) for the preceding fiscal year does not exceed or equal—

(i) 7 percent if the preceding fiscal year is 1990;

(ii) 7 percent if such year is 1991;

(iii) 11 percent if such year is 1992;

(iv) 11 percent if such year is 1993;

(v) 15 percent if such year is 1994; and

(vi) 20 percent if such year is 1995.

(B)(i) The State's participation rate for a fiscal year shall be the average of its participation rates for computation periods (as defined in clause (ii)) in such fiscal year.

(ii) The computation periods shall be—

(I) the fiscal year, in the case of fiscal year 1990,

(II) the first six months, and the seventh through twelfth months, in the case of fiscal year 1991,

(III) the first three months, the fourth through sixth months, the seventh through ninth months, and the tenth through twelfth months, in the case of fiscal years 1992 and 1993, and

(IV) each month, in the case of fiscal years 1994 and 1995.

(iii) The State's participation rate for a computation period shall be the number, expressed as a percentage, equal to—

(I) the average monthly number of individuals required or allowed by the State to participate in the program under part F who have participated in such program in months in the computation period, plus the number of individuals required or allowed by the State to participate in such program who have so participated in that month in such period for which the number of such participants is the greatest, divided by

(II) twice the average monthly number of individuals required to participate in such period (other than individuals described in subparagraph (C)(iii)(I) or (D) of section 402(a)(19) with respect to whom the State has exercised its option to require their participation).

For purposes of this subparagraph, an individual shall not be considered to have satisfactorily participated in the program under part F solely by reason of such individual being registered to participate in such program.

(C) Notwithstanding any other provision of this paragraph, no State shall be subject to payment under this paragraph (in lieu of paragraph (1)(A)) for failing to meet any participation rate required under this paragraph with respect to any fiscal year before 1991.

(D) For purposes of this paragraph, an individual shall be determined to have participated in the program under part F, if such individual has participated in accordance with such requirements, consistent with regulations of the Secretary, as the State shall establish.

(E) If the Secretary determines that the State has failed to achieve the participation rate for any fiscal year specified in the numbered clauses of subparagraph (A), he may waive, in whole or in part, the reduction in the payment rate otherwise required by such subparagraph if he finds that—

(i) the State is in conformity with section 402(a)(19) and part F;

(ii) the State has made a good faith effort to achieve the applicable participation rate for such fiscal year; and

(iii) the State has submitted a proposal which is likely to achieve the applicable participation rate for the current fiscal year and the subsequent fiscal years (if any) specified therein.[84]

(4)(A)(i) Subject to subparagraph (B), in the case of any family eligible for aid to families with dependent children by reason of the unemployment of the parent who is the principal earner, the State agency shall require that at least one parent in any such family participate, for a total of at least 16 hours a week during any period in which either parent is required to participate in the program, in a work supplementation program, a community work experience or other work experience program, on-the-job training, or a State designed work program approved by the Secretary, as such programs are described in section 482(d)(1). In the case of a parent under age 25 who has not completed high school or an equivalent course of education, the State may require such parent to participate in educational activities directed at the attainment of a high school diploma (or equivalent) or another basic education program in lieu of one or more of the programs specified in the preceding sentence.

(ii) For purposes of clause (i), an individual participating in a community work experience program under section 482 shall be considered to have met the requirement of such clause if he participates for the number of hours in any month equal to the monthly payment of aid to families with dependent children to the family of which he is a member, divided by the greater of the Federal or the applicable State minimum wage (and the portion of such monthly payment for which the State is reimbursed by a child support collection shall not be taken into account in determining the number of hours that such individual may be required to work).

(B) The requirement under subparagraph (A) shall not be considered to have been met by any State if the requirement is not met with respect to the following percentages of all families in the State eligible for aid to families with dependent children by reason of the unemployment of the parent who is the principal earner:

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[84] This paragraph is repealed effective October 1, 1995 (except that subparagraph (A) shall remain in effect for purposes of applying any reduction in payment rates required by that subparagraph for any of the fiscal years specified therein).

(i) 40 percent, in the case of the average of each month in fiscal year 1994,

(ii) 50 percent, in the case of the average of each month in fiscal year 1995,

(iii) 60 percent, in the case of the average of each month in fiscal year 1996, and

(iv) 75 percent in the case of the average of each month in each of the fiscal years 1997 and 1998.

(C) The percentage of participants for any month in a fiscal year for purposes of the preceding sentence shall equal the average of—

(i) the number of individuals described in subparagraph (A)(i) who have met the requirement prescribed therein, divided by

(ii) the total number of principal earners described in such subparagraph (but excluding those in families who have been recipients of aid for 2 months or less if, during the period that the family received aid, at least one parent engaged in intensive job search).

(D) If the Secretary determines that the State has failed to meet the requirement under subparagraph (A) (determined with respect to the percentages prescribed in subparagraph (B)), he may waive, in whole or in part, any penalty if he finds that—

(i) the State is operating a program in conformity with section 402(a)(19) and part F,

(ii) the State has made a good faith effort to meet the requirement of subparagraph (A) but has been unable to do so because of economic conditions in the State (including significant numbers of recipients living in remote locations or isolated rural areas where the availability of work sites is severely limited), or because of rapid and substantial increases in the caseload that cannot reasonably be planned for, and

(iii) the State has submitted a proposal which is likely to achieve the required percentage of participants for the subsequent fiscal years.[85]

(m)(1) During the 12-month period beginning on July 1, 1988 (in this subsection referred to as the "moratorium period"), the Secretary shall not impose any reductions in payments to States pursuant to subsection (i) (or prior regulations), or pursuant to any comparable provision of law relating to the programs under this part in Puerto Rico, Guam, the Virgin Islands, American Samoa, or the Northern Mariana Islands.

(2) During the moratorium period—

(A) the Secretary and the States shall continue to operate the quality control systems in effect under this part, and to calculate the error rates under the provisions referred to in paragraph (1), including the process of requesting and reviewing waivers; and

(B) the Departmental Grant Appeals Board shall, notwithstanding paragraph (1), review disallowances for fiscal year 1981 and thereafter and hear appeals with respect thereto (but collection of disallowances owed as a result of Departmental Grant Appeals Board decisions shall not occur).

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[85] P.L. 100-485, §201(c)(2), added subsection (l). For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1). Effective October 1, 1998, paragraph (4) is repealed.

(n)(1) In addition to any payment under subsection (a) or (l), each State shall be entitled to payment from the Secretary of an amount equal to the lesser of—

(A) the Federal medical assistance percentage (as defined in section 1905(b)) of the expenditures by the State in providing child care services pursuant to section 402(i), and in administering the provision of such child care services, for any fiscal year; and

(B) the limitation determined under paragraph (2) with respect to the State for the fiscal year.

(2)(A) The limitation determined under this paragraph with respect to a State for any fiscal year is the amount that bears the same ratio to the amount specified in subparagraph (B) for such fiscal year as the number of children residing in the State in the second preceding fiscal year bears to the number of children residing in the United States in the second preceding fiscal year.

(B) The amount specified in this subparagraph is—

(i) $300,000,000 for fiscal year 1991;

(ii) $300,000,000 for fiscal year 1992;

(iii) $300,000,000 for fiscal year 1993;

(iv) $300,000,000 for fiscal year 1994; and

(v) $300,000,000 for fiscal year 1995, and for each fiscal year thereafter.

(C) If the limitation determined under subparagraph (A) with respect to a State for a fiscal year exceeds the amount paid to the State under this subsection for the fiscal year, the limitation determined under this paragraph with respect to the State for the immediately succeeding fiscal year shall be increased by the amount of such excess.

(3) Amounts appropriated for a fiscal year to carry out this part shall be made available for payments under this subsection for such fiscal year.[86]

OPERATION OF STATE PLANS

SEC. 404. [42 U.S.C. 604] (a) In the case of any State plan for aid and services to needy families with children which has been approved by the Secretary, if the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds—

(1) that the plan has been so changed as to impose any residence requirement prohibited by section 402(b), or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or

(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 402(a) to be included in the plan;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) until the Secretary is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).[87]

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[86] P.L. 101-508, §5081(b), added subsection (n), effective October 1, 1990.

(b) No payment to which a State is otherwise entitled under this part for any period before September 1, 1962, shall be withheld by reason of any action taken pursuant to a State statute which requires that aid be denied under the State plan approved under this part with respect to a child because of the conditions in the home in which the child resides; nor shall any such payment be withheld for any period beginning on or after such date by reason of any action taken pursuant to such a statute if provision is otherwise made pursuant to a State statute for adequate care and assistance with respect to such child.

(c) No State shall be found, prior to January 1, 1977, to have failed substantially to comply with the requirements of section 402(a)(27) if, in the judgment of the Secretary, such State is making a good faith effort to implement the program required by such section.

(d) After December 31, 1976, in the case of any State which is found to have failed substantially to comply with the requirements of section 402(a)(27), the reduction in any amount payable to such State required to be imposed under section 403(h) shall be imposed in lieu of any reduction, with respect to such failure, which would otherwise be required to be imposed under this section.

USE OF PAYMENTS FOR BENEFIT OF CHILD[88]

SEC. 405. [42 U.S.C. 605] Whenever the State agency has reason to believe that any payments of aid to families with dependent children made with respect to a child are not being or may not be used in the best interests of the child, the State agency may provide for such counseling and guidance services with respect to the use of such payments and the management of other funds by the relative receiving such payments as it deems advisable in order to assure use of such payments in the best interests of such child, and may provide for advising such relative that continued failure to so use such payments will result in substitution therefor of protective payments as provided under section 406(b)(2), or in seeking appointment of a guardian or legal representative as provided in section 1111, or in the imposition of criminal or civil penalties authorized under State law if it is determined by a court of competent jurisdiction that such relative is not using or has not used for the benefit of the child any such payments made for that purpose; and the provision of such services or advice by the State agency (or the taking of the action specified in such advice) shall not serve as a basis for withholding funds from such State under section 404 and shall not prevent such payments with respect to such child from being considered aid to families with dependent children.

DEFINITIONS

SEC. 406. [42 U.S.C. 606] When used in this part—

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[87] See Vol. II, P.L. 99-514, §1883(b)(11), with respect to the effect of the failure of a State to comply with certain provisions or the imposition by a State of a requirement inconsistent with certain provisions.

[88] See Vol. II, P.L. 95-608, §§2-113, with respect to Indian child welfare.

(a) The term "dependent child" means a needy child (1) who has been deprived of parental support or care by reason of the death, continued absence from the home (other than absence occasioned solely by reason of the performance of active duty in the uniformed services of the United States), or physical or mental incapacity of a parent, and who is living with his father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece, in a place of residence maintained by one or more of such relatives as his or their own home, and (2) who is (A) under the age of eighteen, or (B) at the option of the State, under the age of nineteen and a full-time student in a secondary school (or in the equivalent level of vocational or technical training), if, before he attains age nineteen, he may reasonably be expected to complete the program of such secondary school (or such training);

(b) The term "aid to families with dependent children" means money payments with respect to a dependent child or dependent children, or, at the option of the State, a pregnant woman but only if it has been medically verified that the child is expected to be born in the month such payments are made or within the three-month period following such month of payment, and who, if such child had been born and was living with her in the month of payment, would be eligible for aid to families with dependent children, and includes (1) money payments to meet the needs of the relative with whom any dependent child is living (and the spouse of such relative if living with him and if such relative is the child's parent and the child is a dependent child by reason of the physical or mental incapacity of a parent or is a dependent child under section 407), and (2) payments with respect to any dependent child (including payments to meet the needs of the relative, and the relative's spouse, with whom such child is living, and the needs of any other individual living in the same home if such needs are taken into account in making the determination under section 402(a)(7)) which do not meet the preceding requirements of this subsection, but which would meet such requirements except that such payments are made to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such child or relative, or are made on behalf of such child or relative directly to a person furnishing food, living accommodations, or other goods, services, or items to or for such child, relative, or other individual, but only with respect to a State whose State plan approved under section 402 includes provision for—

(A) determination by the State agency that the relative of the child with respect to whom such payments are made has such inability to manage funds that making payments to him would be contrary to the welfare of the child and, therefore, it is necessary to provide such aid with respect to such child and relative through payments described in this clause (2);

(B) undertaking and continuing special efforts to develop greater ability on the part of the relative to manage funds in such manner as to protect the welfare of the family;

(C) periodic review by such State agency of the determination under clause (A) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that the need for such payments is continuing, or is likely to continue, beyond a period specified by the Secretary; and

(D) opportunity for a fair hearing before the State agency on the determination referred to in clause (A) for any individual with respect to whom it is made.

Payments with respect to a dependent child which are intended to enable the recipient to pay for specific goods, services, or items recognized by the State agency as a part of the child's need under the State plan may (in the discretion of the State or local agency administering the plan in the political subdivision) be made, pursuant to a determination referred to in clause (2)(A), in the form of checks drawn jointly to the order of the recipient and the person furnishing such goods, services, or items and negotiable only upon endorsement by both such recipient and such person; and payments so made shall be considered for all of the purposes of this part to be payments described in clause (2). Whenever payments with respect to a dependent child are made in the manner described in clause (2) (including payments described in the preceding sentence), a statement of the specific reasons for making such payments in that manner (on which the determination under clause (2)(A) was based) shall be placed in the file maintained with respect to such child by the State or local agency administering the State plan in the political subdivision. Payments of the type described in clause (2) shall not be subject to the requirements of clauses (A) through (D) of such clause (2), when they are made in the manner described in clause (2) at the request of the family member to whom payment would otherwise be made in an unrestricted manner.

(c) The term "relative with whom any dependent child is living" means the individual who is one of the relatives specified in subsection (a) and with whom such child is living (within the meaning of such subsection) in a place of residence maintained by such individual (himself or together with any one or more of the other relatives so specified) as his (or their) own home.

[(d) Repealed.[89]**]**

(e)(1) The term "emergency assistance to needy families with children" means any of the following, furnished for a period not in excess of 30 days in any 12-month period, in the case of a needy child under the age of 21 who is (or, within such period as may be specified by the Secretary, has been) living with any of the relatives specified in subsection (a)(1) in a place of residence maintained by one or more of such relatives as his or their own home, but only where such child is without available resources, the payments, care, or services involved are necessary to avoid destitution of such child or to provide living arrangements in a home for such child, and such destitution or need for living arrangements did not arise because such child or relative refused without good cause to accept employment or training for employment—

(A) money payments, payments in kind, or such other payments as the State agency may specify with respect to, or medical care or any other type of remedial care recognized under State law (for which such individual is not entitled to medical assistance under the State plan under title XIX) on behalf of, such child or any other member of the household in which he is living, and

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[89] P.L. 97-35, §2353(b)(1); 95 Stat. 872.

(B) such services as may be specified by the Secretary;

but only with respect to a State whose State plan approved under section 402 includes provision for such assistance.

(2) Emergency assistance as authorized under paragraph (1) may be provided under the conditions specified in such paragraph to migrant workers with families in the State or in such part or parts thereof as the State shall designate.[90]

(f) Notwithstanding the provisions of subsection (b), the term "aid to families with dependent children" does not mean payments with respect to a parent (or other individual whose needs such State determines should be considered in determining the need of the child or relative claiming aid under the plan of such State approved under this part) of a child who fails to cooperate with any agency or official of the State in obtaining such support payments for such child. Nothing in this subsection shall be construed to make an otherwise eligible child ineligible for protective payments because of the failure of such parent (or such other individual) to so cooperate.

(g) Notwithstanding the provisions of subsection (b), the term "aid to families with dependent children" does not mean any—

(1) amount paid to meet the needs of an unborn child; or

(2) amount paid (or by which a payment is increased) to meet the needs of a woman occasioned by or resulting from her pregnancy, unless, as has been medically verified, the woman's child is expected to be born in the month such payments are made (or increased) or within the three-month period following such month of payment.

(h) Each dependent child, and each relative with whom such a child is living (including the spouse of such relative as described in subsection (b)), who becomes ineligible for aid to families with dependent children as a result (wholly or partly) of the collection or increased collection of child or spousal support under part D, and who has received such aid in at least three of the six months immediately preceding the month in which such ineligibility begins, shall be deemed to be a recipient of aid to families with dependent children for purposes of title XIX for an additional four calendar months beginning with the month in which such ineligibility begins.[91]

DEPENDENT CHILDREN OF UNEMPLOYED PARENTS[92]

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[90] See Vol. II, P.L. 100-647, §8102, with respect to the Secretary's review of the policy governing use of AFDC funds to meet emergency needs of families eligible for AFDC through emergency assistance or special needs payments and a report to Congress.

See Vol. II, P.L. 101-239, §8005 [as amended by P.L. 101-508, §5058], with respect to emergency assistance and AFDC special needs.

[91] P.L. 98-378, §20 [as amended by P.L. 100-485, §303(e) and P.L. 101-239, §8003(a)], added subsection (h), applicable only with respect to individuals becoming ineligible for aid to families with dependent children (as described in section 406(h) of the Act) on or after August 16, 1984*.

*P.L. 101-239, §8003(a), struck out "and before October 1, 1989".

[92] See Vol. II, P.L. 100-485, §401(e), with respect to an evaluation and report relating to the time-limited and conventional State programs.

SEC. 407. [42 U.S.C. 607] (a) The term "dependent child" shall, notwithstanding section 406(a), include a needy child who meets the requirements of section 406(a)(2), who has been deprived of parental support or care by reason of the unemployment (as determined in accordance with standards prescribed by the Secretary) of the parent who is the principal earner, and who is living with any of the relatives specified in section 406(a)(1) in a place of residence maintained by one or more of such relatives as his (or their) own home.

(b)(1) In providing for the provision of aid to families with dependent children under the State's plan approved under section 402, in the case of families that include dependent children within the meaning of subsection (a) of this section, as required by section 402(a)(41), the State's plan—

(A) subject to paragraph (2),[93] shall require[94] the payment of aid to families with dependent children with respect to a dependent child as defined in subsection (a) when—

(i) whichever of such child's parents is the principal earner has not been employed (as determined in accordance with standards prescribed by the Secretary) for at least 30 days prior to the receipt of such aid,

(ii) such parent has not without good cause, within such period (of not less than 30 days) as may be prescribed by the Secretary, refused a bona fide offer of employment or training for employment, and

(iii)(I) such parent has 6 or more quarters of work (as defined in subsection (d)(1)), no more than 4 of which may be quarters of work defined in subsection (d)(1)(B),[95] in any 13-calendar-quarter period ending within one year prior to the application for such aid or (II) such parent received unemployment compensation under an unemployment compensation law of a State or of the United States, or such parent was qualified (within the meaning of subsection (d)(3)) for unemployment compensation under the unemployment compensation law of the State, within one year prior to the application for such aid; and

(B) shall provide[96]—

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[93] P.L. 100-485, §401(b)(1)(B), inserted "subject to paragraph (2)," effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

[94] P.L. 100-485, §401(a)(2)(B), struck out "The provisions of subsection (a) shall be applicable to a State if the State's plan approved under section 402—

"(1) requires" and substituted "In providing for the provision of aid to families with dependent children under the State's plan approved under section 402, in the case of families that include dependent children within the meaning of subsection (a) of this section, as required by section 402(a)(41), the State's plan—

"(1) shall require", effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

[95] P.L. 100-485, §401(c)(3), inserted ", no more than 4 of which may be quarters of work defined in subsection (d)(1)(B),", effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

[96] P.L. 100-485, §401(a)(2)(C), struck out "provides" and substituted "shall provide", effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective

(i) for such assurances as will satisfy the Secretary that unemployed parents of dependent children as defined in subsection (a) will participate or apply for participation in a program under part F (unless the program is not available in the area where the parent is living)[97] within 30 days after receipt of aid with respect to such children;

(ii)[98] for entering into cooperative arrangements with the State agency responsible for administering or supervising the administration of vocational education in the State, designed to assure maximum utilization of available public vocational education services and facilities in the State in order to encourage the retraining of individuals capable of being retrained;

(iii)[99] for the denial of aid to families with dependent children to any child or relative specified in subsection (a)[100] with respect to any week for which such child's parent described in subparagraph (A)(i)[101] qualifies for unemployment compensation under an unemployment compensation law of a State or of the United States, but refuses to apply for or accept such unemployment compensation;[102]

(iv)[103] for the reduction of the aid to families with depend-

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September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

[97] P.L. 100-485, §202(b)(7), struck out "be certified to the Secretary of Labor as provided in section 402(a)(19)" and substituted "participate or apply for participation in a program under part F (unless the program is not available in the area where the parent is living)". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

[98] P.L. 100-485, §401(b)(1)(A)(iv). redesignated subparagraph (B) as clause (ii).

[99] P.L. 100-485, §401(b)(1)(A)(iv), redesignated subparagraph (C) as clause (iii).

[100] P.L. 101-508, §5061(a)(1)(A), struck out a dash, "(I) if and for so long as such child's parent described in subparagraph (A)(i)*, unless exempt under section 402(a)(19)(C)**, is not currently participating (or available for participation) in a program under part F***, or, if he is exempt under such section by reason of clause (vii)**** thereof or no such program in which he can effectively participate has been established or provided under part F*****, is not currently registered with the public employment offices in the State, and (II)", effective at the same time and in the same manner as the amendments made by P.L. 100-485, §202.

*P.L. 100-485, §401(b)(3)(A), struck out "paragraph (1)(A)" and substituted "subparagraph (A)(i)", effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

**P.L. 100-485, §202(b)(8)(A), struck out "402(a)(19)(A)" and substituted "409(a)(19)(C)". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

P.L. 100-647, §8105(5), struck out "409(a)(19)(A)" and substituted "402(a)(19)(A)", effective as if included in the enactment of P.L. 100-485, §202(b)(8)(A).

P.L 101-239, §10403(a)(1)(A)(i), struck out "409(a)(19)(C)" and substituted "402(a)(19)(C)", effective as if included in the enactment of P.L. 100-485.

***P.L. 100-485, §202(b)(8)(A), struck out ", is not currently registered pursuant to such section for the work incentive program established under part C of this title" and substituted ", is not currently participating (or available for participation) in a program under part F". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

****P.L. 100-485, §202(b)(8)(B), struck out "(iii)" and substituted "(vii)". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

*****P.L. 100-485, §202(b)(8)(C), struck out "section 432(a)" and substituted "part F". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

[101] P.L. 100-485, §401(b)(3)(A), struck out "paragraph (1)(A)" and substituted "subparagraph (A)(i)", effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

[102] P.L. 101-508, §5061(a)(1)(B), struck out "and".

[103] P.L. 100-485, §401(b)(1)(A)(iv), redesignated subparagraph (D) as clause (iv).

ent children otherwise payable to any child or relative specified in subsection (a) by the amount of any unemployment compensation that such child's parent described in subparagraph (A)(i)[104] receives under an unemployment compensation law of a State or of the United States; and[105]

(v) that, if and for so long as the child's parent described in subparagraph (A)(i), unless meeting a condition of section 402(a)(19)(C), is, without good cause, not participating (or available for participation) in a program under part F, or if exempt under such section by reason of clause (vii) thereof or because there has not been established or provided under part F a program in which such parent can effectively participate, is not registered with the public employment offices in the State, the needs of such parent shall not be taken into account in determining the need of such parent's family under section 402(a)(7), and the needs of such parent's spouse shall not be so taken into account unless such spouse is participating in such a program, or if not participating solely by reason of section 402(a)(19)(C)(vii) or because there has not been established or provided under part F a program in which such spouse can effectively participate, is registered with the public employment offices of the State; and if neither parents'[106] needs are so taken into account, the payment provisions of section 402(a)(19)(G)(i)(I) shall apply.[107]

(2)(A) In carrying out the program under this section, a State may design its program to reflect the individual needs of the State and to emphasize education, training, and employment services for unemployed parents and their spouses who are eligible for aid to families with dependent children by reason of this section, to the extent provided under this paragraph.

(B)(i) Subject to clauses (ii) and (iii), with respect to the requirement under section 402(a)(41), a State may, at its option, limit the number of months with respect to which a family receives aid to families with dependent children to the extent determined appropriate by the State for the operation of its program under this section.

(ii)(I) A State may not limit the number of months under clause (i) for which a family may receive aid to families with dependent children unless it provides in its plan assurances to the Secretary that it has a program (that meets such requirements as the Secretary may in regulation prescribe) for providing education, training, and employment services (including any activity authorized under section 402(a)(19) or under part F) in order to assist parents of children described in subsection (a) in preparing for and obtaining employment.

(II) In exercising the option under clause (i), a State plan may not provide for the denial of aid to families with dependent children to a family otherwise eligible for such aid for any month unless the family has received such aid (on the basis of the unemployment of the parent who is the principal earner) in at least 6 of the preceding 12 months.

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[104] P.L. 100-485, §401(b)(3)(A), struck out "paragraph (1)(A)" and substituted "subparagraph (A)(i)", effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

[105] P.L. 101-508, §5061(a)(2), struck out a period and substituted "; and".

[106] As in original. Probably should be "parent's".

[107] P.L. 101-508, §5061(a)(3), added clause (v), effective at the same time and the same manner as the amendment made by P.L. 100-485, §202.

(III) Any family that is otherwise eligible for aid to families with dependent children that does not receive such aid in any month solely by reason of the State exercising the option under clause (i) shall be deemed, for purposes of determining the period under paragraph (1)(A)(iii)(I), to be receiving such aid in such month.[108]

(iii) Each State which, on September 26, 1988, has a program in effect under this section shall continue to operate such program without a time limitation.

(C) With respect to the participation in the program under section 402(a)(19) and part F of a family eligible for aid to families with dependent children by reason of this section, a State may, at its option—

(i) except as otherwise provided in such section and such part, require that any parent participating in such program engage in program activities for up to 40 hours per week; and

(ii) provide for the payment of aid to families with dependent children at regular intervals of no greater than one month but after the performance of assigned program activities.[109]

(c) Notwithstanding any other provisions of this section, expenditures pursuant to this section shall be excluded from aid to families with dependent children (A) where such expenditures are made under the plan with respect to any dependent child as defined in subsection (a), (i) for any part of the 30-day period referred to in subsection (b)(1)(A)(i)[110], or (ii) for any period prior to the time when the parent satisfies subsection (b)(1)(A)(ii)[111], and (B) if, and for as long as, no action is taken (after the 30-day period referred to in subsection (b)(1)(B)(i)[112]), under the program therein specified, to undertake appropriate steps directed towards the participation of such parent in a program under part F[113].

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[108] P.L. 100-485, §401(c)(4)(A), added subclause (III), effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

[109] P.L. 100-485, §401(b)(1)(C), added paragraph (2), effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

[110] P.L. 100-485, §401(b)(3)(B)(i), struck out "subparagraph (A) of subsection (b)(1)" and substituted "subsection (b)(1)(A)(i)", effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

[111] P.L. 100-485, §401(b)(3)(B)(ii), struck out "subparagraph (B) of such subsection" and substituted "subsection (b)(1)(A)(ii)", effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

[112] P.L. 100-485, §401(b)(3)(B)(iii), struck out "subparagraph (A) of subsection (b)(2)" and substituted "subsection (b)(1)(B)(i)", effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

(d) For purposes of this section—

(1) the term "quarter of work" with respect to any individual means (A) a calendar quarter[114] in which such individual received earned income of not less than $50 (or which is a "quarter of coverage" as defined in section 213(a)(2)), or in which such individual participated in a program under part F[115],[116] (B) at the option of the State, a calendar quarter in which such individual attended, full-time, an elementary school, a secondary school, or a vocational or technical training course (approved by the Secretary) that is designed to prepare the individual for gainful employment, or in which such individual participated in an education or training program established under the Job Training Partnership Act[117], and (C) a calendar quarter ending before October 1990 in which such individual participated in a community work experience program under section 409 (as in effect for a State immediately before the effective date for that State of the amendments made by title II of the Family Support Act of 1988[118]) or the work incentive program established under part C (as in effect for a State immediately before such effective date)[119];

(2) the term "calendar quarter" means a period of 3 consecutive calendar months ending on March 31, June 30, September 30, or December 31;

(3) an individual shall, for purposes of subsection (b)(1)(A)(iii)[120], be deemed qualified for unemployment compensation under the State's unemployment compensation law if—

(A) he would have been eligible to receive such unemployment compensation upon filing application, or

(B) he performed work not covered under such law and such work, if it had been covered, would (together with any covered work he performed) have made him eligible to receive such unemployment compensation upon filing application; and

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[113] P.L. 100-485, §202(b)(9), struck out "certify such parent to the Secretary of Labor pursuant to section 402(a)(19)" and substituted "undertake appropriate steps directed towards the participation of such parent in a program under part F". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

[114] P.L. 101-508, §5062(a)(1), struck out "a calendar quarter (A)" and substituted "(A) a calendar quarter", effective November 5, 1990.

[115] P.L. 100-485, §202(b)(10), struck out "community work experience program under section 409, or the work incentive program established under part C;" and substituted "program under part F". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

P.L. 100-647, §8105(3), struck out P.L. 100-485, §202(b)(10), effective October 13, 1988.

P.L. 100-485, §401(c)(4)(B), struck out "a community work experience program under section 409, or the work incentive program established under part C;" and substituted "the program under section 402(a)(19) and part F;" effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

P.L. 101-239, §10403(a)(2), struck out "participated in the program under section 402(a)(19) and" and substituted "participated in a program under part F", effective September 30, 1998.

[116] P.L. 101-508, §5062(a)(2), struck out "or".

[117] P.L. 100-485, §401(c)(1)(B), inserted ", or" and subparagraph (B), effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

[118] P.L. 100-485.

[119] P.L. 101-508, §5062(a)(3), added ", and" and subparagraph (C), effective November 5, 1990.

[120] P.L. 100-485, §401(b)(3)(C), struck out "section 407(b)(1)(C)" and substituted "subsection (b)(1)(A)(iii)", effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

(4) the phrase "whichever of such child's parents is the principal earner", in the case of any child, means whichever parent, in a home in which both parents of such child are living, earned the greater amount of income in the 24-month period the last month of which immediately precedes the month in which an application is filed for aid under this part on the basis of the unemployment of a parent, for each consecutive month for which the family receives such aid on that basis.

Notwithstanding section 402(a)(1), a State that chooses to exercise the option provided under paragraph (1)(B) may provide that the definition of calendar quarter under such option apply in one or more political subdivisions of the State.[121]

(e) The Secretary and the Secretary of Labor shall jointly enter into an agreement with each State which is able and willing to do so for the purpose of (1) simplifying the procedures to be followed by unemployed parents and other unemployed persons in such State in participating in a program under part F[122] and in registering with public employment offices (under this section and otherwise) or in connection with applications for unemployment compensation, by reducing the number of locations or agencies where such persons must go in order to participate in or[123] register for such programs and in connection with such applications, and (2) providing where possible for a single registration satisfying this section and the requirements of both part F[124] and the applicable unemployment compensation laws.

Sec. 408. [42 U.S.C. 608] AFDC QUALITY CONTROL SYSTEM.[125]

(a) In General.—In order to improve the accuracy of payments of aid to families with dependent children, the Secretary shall establish and operate a quality control system under which the Secretary shall determine, with respect to each State, the amount (if any) of the disallowance required to be repaid to the Secretary due to erroneous payments made by the State in carrying out the State plan approved under this part.

(b) Review of Cases.—

(1) State review.—

(A) In General.—Each State with a plan approved under this part shall for each fiscal year, in accordance with the time schedule and methodology prescribed in regulations issued under paragraphs (1) and (2) of subsection (h)—

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[121] P.L. 100-485, §401(c)(2), added this sentence, effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992. Effective September 30, 1998, this amendment is repealed and the provision of law (as in effect immediately before the effective date of this amendment) shall apply as if this amendment had never been made.

[122] P.L. 100-485, §202(b)(11)(A), struck out "registering pursuant to section 402(a)(19) for the work incentive program established by part C of this title" and substituted "participating in a program under part F". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

[123] P.L. 100-485, §202(b)(11)(B), inserted "participate in or". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

[124] P.L. 100-485, §202(b)(11)(C), struck out "the work incentive program" and substituted "part F". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

[125] P.L. 101-239, §8004(a), added §408, applicable to erroneous payments made in any fiscal year after fiscal year 1990.

See Vol. II, P.L. 101-239, §8004(e) and (f), with respect to implementation and annual reports.

(i) review a sample of cases in the State with respect to which a payment has been made under such plan during the fiscal year; and

(ii) determine the level of erroneous payments for the State for the fiscal year.

(B) EFFECTS OF FAILURE TO COMPLETE REVIEW IN A TIMELY MANNER.—

(i) SECRETARY CONDUCTS REVIEW.—If a State fails to conduct and complete, on a timely basis, a review required by subparagraph (A), or otherwise fails to cooperate with the Secretary in implementing this subsection, the Secretary, directly or through contractual or such other arrangements as the Secretary may find appropriate, shall conduct the review and establish the error rate for the State for the fiscal year on the basis of the best data reasonably available to the Secretary, in accordance with the statistical methods that would apply if the review were conducted by the State.

(ii) STATE INCURS COSTS OF REVIEW.—The amount that would otherwise be payable under this part to a State for which the Secretary conducts a review under clause (i) shall be reduced by the costs incurred by the Secretary in conducting the review.

(2) REVIEW BY THE SECRETARY.—The Secretary shall review a subsample of the cases reviewed by the State, or by the Secretary with respect to the State, under paragraph (1).

(3) NOTIFICATION OF DIFFERENCE CASES.—Upon completion of the review under paragraph (2), the Secretary shall notify the State of any case in the subsample which the Secretary finds involves erroneous payments, and which the State's review determined to be correct (in this section referred to as a "difference case").

(4) ESTABLISHMENT OF QUALITY CONTROL REVIEW PANEL.—The Secretary shall by regulation establish a Quality Control Review Panel to review difference cases.

(5) RESOLUTION OF DIFFERENCE CASES.—

(A) IN GENERAL.—The State may seek review by the Panel of any difference case, within the time period prescribed in regulations issued under subsection (h)(3).

(B) PROCEDURAL RULES.—The State and the Secretary may submit such documentation to the Panel as the State or the Secretary finds appropriate to substantiate its position. The findings of the Panel shall be made on the record, within the time period prescribed in regulations issued under subsection (h)(4).

(C) STATUS OF DECISIONS OF THE QUALITY CONTROL REVIEW PANEL.—The decisions of the Panel shall constitute the decisions of the Secretary for purposes of establishing the State's error rate for the fiscal year.

(D) APPEALABILITY OF DECISIONS OF THE QUALITY CONTROL REVIEW PANEL.—The decisions of the Panel shall not be appealable, except as provided in subsection (k).

(c) IDENTIFICATION OF ERRONEOUS PAYMENTS.—

(1) APPLY PROVISIONS OF STATE PLAN.—Except as provided in paragraph (2), in determining whether a payment is an erroneous payment, the State and the Secretary shall apply all relevant provisions of the State plan approved under this part.

(2) TREATMENT OF PROVISIONS OF STATE PLAN THAT ARE INCONSISTENT WITH FEDERAL LAW.—

(A) IN GENERAL.—If a provision of a State plan approved under this part is inconsistent with a provision of Federal law or regulations, and the Secretary has notified the State of the inconsistency, the provision of Federal law or regulations shall control.

(B) EXCEPTION.—Subparagraph (A) shall not apply with respect to a payment of the State if—

(i) it is necessary for the State to enact a law in order to remove an inconsistency described in subparagraph (A), the Secretary has advised the State that the State will be allowed a reasonable period in which to enact such a law, and the payment was made during such period; or

(ii) the State agency made the payment in compliance with a court order.

(3) CERTAIN PAYMENTS NOT CONSIDERED ERRONEOUS.—For purposes of this section, a payment by a State shall not be considered an erroneous payment if the payment is in error solely by reason of—

(A) the State's failure to implement properly changes in Federal statute within 6 months after the effective date of such changes or, if later, 6 months after the issuance of final regulations (including regulations in interim final form) if such regulations are reasonably necessary to construe or apply the Federal statutory change;

(B) the State's reliance upon and correct use of erroneous information provided by the Secretary about matters of fact;

(C) the State's reliance upon and correct use of written statements of Federal policy provided to the State by the Secretary;

(D) the occurrence of an event in the State that—

(i) results in the declaration by the President or the Governor of the State of a state of emergency or major disaster; and

(ii) directly affects the State agency's ability to make correct payments under the State plan approved under this part; or

(E) the failure of a family to submit monthly reports to the State pursuant to section 402(a)(14), if the failure did not affect the amount of the payment.

(4) CERTAIN PAYMENTS CONSIDERED ERRONEOUS.—Notwithstanding any other provision of this section, a payment shall be considered an erroneous payment if the payment is made to a family—

(A) which has failed without good cause to assign support rights as required by section 402(a)(26); or

(B) any member of which is a recipient of aid under a State plan approved under this part and does not have a social security account number (unless an application for a social security account number for the family member has been filed within 30 days after the date of application for such aid).

(d) DETERMINATION OF ERROR RATES.—

(1) IN GENERAL.—The Secretary shall, in accordance with this subsection, determine an error rate for each State for the fiscal year involved, based on the reviews under paragraphs (1) and (2) of subsection (b) and the decisions of the Quality Control Review Panel under subsection (b)(5).

(2) ERROR RATE FORMULA.—Except as provided in paragraph (3), the State's error rate for a fiscal year is—

(A) the ratio of—

(i) the erroneous payments of the State for the fiscal year; to

(ii) the total payments of aid under the State plan approved under this part for the fiscal year; reduced by

(B) the amount by which—

(i) the national average underpayment rate for the fiscal year; exceeds

(ii) the underpayment rate of the State for the fiscal year.

(3) APPLICATION OF REDUCTION TO SUBSEQUENT FISCAL YEAR.—At the request of a State, the Secretary shall apply the reduction described in paragraph (2)(B) in determining the State's error rate for either of the 2 following fiscal years instead of in determining the State's error rate for the fiscal year to which the reduction would otherwise apply.

(e) NOTIFICATION TO STATES OF ERROR RATES.—The Secretary shall notify each State of the error rate of the State determined under subsection (d), within the time period precribed in regulations issued under subsection (h)(5).

(f) IMPOSITION OF DISALLOWANCES.—If a State's error rate for the fiscal year exceeds the national average error rate for the fiscal year, the Secretary shall impose a disallowance on the State for the fiscal year in an amount equal to—

(1) the product of—

(A) the State's total payments of aid to families with dependent children for the fiscal year;

(B) the Federal medical assistance percentage applicable to the State for purposes of section 1118;

(C) the lesser of—

(i) the ratio of—

(I) the amount by which the State's error rate for the fiscal year exceeds the national average error rate for the fiscal year; to

(II) the national average error rate for the fiscal year; or

(ii) 1; and

(D) the amount by which the State's error rate for the fiscal year exceeds the national average error rate for the fiscal year;

reduced by

(2) the product of—

(A) the ratio of—

(i) the amount by which the State's error rate for the fiscal year exceeds the national average error rate for the fiscal year; and

(ii) the State's error rate for the fiscal year;

(B) the overpayments recovered by the State in the fiscal year; and

(C) the Federal medical assistance percentage applicable to the State for purposes of section 1118;

and further reduced by

(3) the product of—

(A) the calculation described in paragraphs (1) and (2); and

(B) the percentage by which—

(i) the State's rate of child support collections for the fiscal year; exceeds

(ii) the lesser of—

(I) the national average rate of child support collections for the fiscal year; or

(II) the average of the State's child support collection rates for each of the 3 fiscal years preceding the fiscal year.

(g) Notification to States of Amounts of Disallowances.—The Secretary shall notify each State on which the Secretary imposes a disallowance the amount of the disallowance, within the time period prescribed in regulations issued under subsection (h)(6).

(h) Regulations.—The Secretary, after consultation with the chief executives of the States, shall by regulation prescribe—

(1) the periods within which—

(A) the reviews required by paragraphs (1) and (2) of subsection (b) are to begin and be completed; and

(B) the results of the review required by subsection (b)(1) are to be reported to the Secretary;

(2) matters relating to the selection and size of the samples to be reviewed under paragraphs (1) and (2) of subsection (b), and the methodology for making statistically valid estimates of each State's error rate;

(3) the period within which a State may seek review by the Quality Control Review Panel of a difference case;

(4) the period within which a difference case appealed by a State is to be resolved by the Quality Control Review Panel;

(5) the period, after the completion of the reviews required by paragraphs (1) and (2) of subsection (b) and the resolution by the Quality Control Review Panel of any difference cases appealed by a State, within which the Secretary is to notify the State of the error rate of the State for the fiscal year involved; and

(6) the period within which the Secretary is to notify a State of any disallowance.

(i) Payment of Disallowances.—

(1) Payment options.—Within 45 days after the date a State is notified of a disallowance pursuant to subsection (g), the State shall, at the option of the State—

(A) pay the Secretary the amount of the disallowance; or

(B) enter into an agreement with the Secretary under which the State will make quarterly payments to the Secretary over a period not to exceed 30 months beginning not later than the first quarter beginning after the date the State receives the notice, in amounts sufficient to repay the disallowance with interest by the end of such period.

(2) AUTHORITY TO ADJUST STATE MATCHING PAYMENTS.—If a State fails to pay the amount of a disallowance imposed on the State, in the manner required by the applicable subparagraph of paragraph (1), the Secretary shall reduce the amount to be paid to the State under section 403(a) by amounts sufficient to recover the amount of the disallowance with interest.

(3) INTEREST ON UNPAID DISALLOWANCES.—

(A) RATE OF INTEREST.—Interest on the unpaid amount of a disallowance shall accrue at the overpayment rate established under section 6621(a)(1) of the Internal Revenue Code of 1986.

(B) ACCRUAL OF INTEREST.—

(i) IN GENERAL.—Except as provided in clause (ii), interest on the unpaid amount of a State's disallowance shall accrue beginning 45 days after the date the State receives notice of the disallowance.

(ii) EXCEPTION.—If the State appeals the imposition of a disallowance under this section to the Departmental Appeals Board and the Board does not decide the appeal within 90 days after the date of the State's notice of appeal, interest shall not accrue on the unpaid amount of the disallowance during the period beginning on such 90th day and ending on the date of the Board's final decision on the appeal, except to the extent that the Board finds that the State caused or requested the delay.

(j) ADMINISTRATIVE REVIEW OF DISALLOWANCES.—

(1) IN GENERAL.—Within 60 days after the date a State receives notice of a disallowance imposed under this section, the State may appeal the imposition of the disallowance, in whole or in part, to the Departmental Appeals Board established in the Department of Health and Human Services, by filing an appeal with the Board.

(2) PROCEDURAL RULES.—The Board shall consider a State's appeal on the basis of such documentation as the State may submit and as the Board may require to support the final decision of the Board. In deciding whether to uphold a disallowance or any portion thereof, the Board shall conduct a thorough review of the issues and take into account all relevant evidence. In rendering its final decision, the Board shall incorporate by reference any findings of the Quality Control Review Panel that were made in connection with the determination of the error rate and the amount of the disallowance, and such findings shall not be reviewable by the Board.

(k) JUDICIAL REVIEW OF DISALLOWANCES.—

(1) IN GENERAL.—Within 90 days after the date of a final decision by the Departmental Appeals Board with respect to the imposition of a disallowance on a State under this section, the State may obtain judicial review of the final decision (and the findings of the Quality Control Review Panel incorporated into the final decision) by filing an action in—

(A) the district court of the United States for the judicial district in which the principal or headquarters office of the State agency is located; or

(B) the United States District Court for the District of Columbia.

(2) PROCEDURAL RULES.—The district court in which an action is filed shall review the final decision of the Board on the record established in the administrative proceeding, in accordance with the standards of review prescribed by subparagraphs (A) through (E) of section 706(2) of title 5, United States Code. The review shall be on the basis of the documents and supporting data submitted to the Board (or to the Quality Control Review Panel, in the case of any finding by the Panel which is at issue in the appeal).

(l) REFUND OF DISALLOWANCES IMPOSED IN ERROR.—If the Secretary, directly or indirectly, receives from a State part or all of the amount of a disallowance imposed on the State under this section, and part or all of the disallowance is finally determined to have been imposed in error, the Secretary shall refund to the State the amount received by reason of the error, with interest which shall accrue from the date of receipt at the rate described in subsection (i)(3)(A).

(m) DEFINITIONS.—As used in this section:

(1) NATIONAL AVERAGE ERROR RATE.—The term "national average error rate" for a fiscal year means the greater of—

(A) the ratio of—

(i) the total amount of erroneous payments made by all States for the fiscal year; to

(ii) the total amount of aid paid by all the States for the fiscal year under plans approved under this part; or

(B) 4 percent.

(2) UNDERPAYMENT RATE.—The term "underpayment rate", with respect to a State for a fiscal year, means the ratio of—

(A) the total amounts of aid that should have been but were erroneously not paid for a fiscal year to recipients of aid under the State plan approved under this part; to

(B) the total amount of aid paid under such plan for the fiscal year.

(3) NATIONAL AVERAGE UNDERPAYMENT RATE.—The term "national average underpayment rate" for a fiscal year means the ratio of—

(A) the total amounts of aid that should have been but were erroneously not paid for a fiscal year to all recipients of aid under State plans approved under this part; to

(B) the total amount of aid paid for the fiscal year under all State plans approved under this part.

(4) CHILD SUPPORT COLLECTION RATE.—The term "child support collection rate", with respect to a State for a fiscal year, means the ratio of—

(A) the sum of the number of cases reported by the agency administering the State plan approved under part D for each quarter in the fiscal year for which—

(i) an assignment was made under section 402(a)(26); and

(ii) a collection was made under the State's plan approved under part D; to

(B) the sum of the number of cases reported by such agency for each quarter in the fiscal year under which an assignment was made under section 402(a)(26).

(5) National child support collection rate.—The term "national child support collection rate" for a fiscal year means the ratio of—

(A) the sum of the number of cases described in paragraph (4)(A) reported by all States for quarters in the fiscal year; to

(B) the sum of the number of cases described in paragraph (4)(B) reported by all States for quarters in the fiscal year.

(6) Erroneous payments.—The term "erroneous payments" means the sum of overpayments to eligible families and payments to ineligible families made in carrying out a plan approved under this part.

EXCLUSION FROM AFDC UNIT OF CHILD FOR WHOM FEDERAL, STATE, OR LOCAL FOSTER CARE MAINTENANCE OR ADOPTION ASSISTANCE PAYMENTS ARE MADE[126]

Sec. 409. [42 U.S.C. 609] (a) Notwithstanding any other provision of this title (other than subsection (b))—

(1) a child with respect to whom foster care maintenance payments or adoption assistance payments are made under part E or under State or local law shall not, for the period for which such payments are made, be regarded as a member of a family for purposes of determining the amount of benefits of the family under this part; and

(2) the income and resources of such child shall be excluded from the income and resources of a family under this part.

(b) Subsection (a) shall not apply in the case of a child with respect to whom adoption assistance payments are made under part E or under State or local law, if application of such subsection would reduce the benefits under this part of the family of which the child would otherwise be regarded as a member.

FOOD STAMP DISTRIBUTION[127]

Sec. 410. [42 U.S.C. 610] (a) Any State plan for aid and services to needy families with children may (but is not required under this title or any other provision of Federal law to) provide for the institution of procedures, in any or all areas of the State, by the State agency administering or supervising the administration of such plan under which any household participating in the food stamp program established by the Food Stamp Act of 1977, as amended, will be entitled, if it so elects, to have the charges, if any, for its coupon allotment under such program deducted from any aid, in the form of money payments, which is (or, except for the deduction of such charge, would be) payable to or with respect to such household (or any member or members thereof) under such plan and have its coupon allotment distributed to it with such aid.

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[126] P.L. 100-485, §202(b)(12), repealed §409, effective October 1, 1990, except as provided in Vol. II, P.L. 100-485, §204(b)(1). [For §409 as it reads until then, see Vol. III, P.L. 100-485.]

P.L. 101-508, §5052(a), added this section 409, applicable to benefits for months beginning on or after May 1, 1991.

[127] See Vol. II, P.L. 88-525, §11(i) with respect to acceptance of applications for participation in the food stamp program and §16(e) with respect to use of the social security number for participation in the food stamp program.

(b) Any deduction made pursuant to an option provided in accordance with subsection (a) shall not be considered to be a payment described in section 406(b)(2).

(c) Notwithstanding any other provision of law, no agency which is designated as a State agency for any State under or pursuant to the Food Stamp Act of 1977, as amended, shall be regarded as having failed to comply with any requirement imposed by or pursuant to such Act solely because of the failure, of the State agency administering or supervising the administration of the State plan (approved under this part) of such State, to institute or carry out a procedure, described in subsection (a).

[SEC. 411. Repealed.[128]]

PRORATING SHELTER ALLOWANCE OF AFDC FAMILY LIVING WITH ANOTHER HOUSEHOLD

SEC. 412. [42 U.S.C. 612] A State plan for aid and services to needy families with children may provide that, in determining the need of any dependent child or relative claiming aid who is living with other individuals (not claiming aid together with such child or relative) as a household (as defined, for purposes of this section, by the Secretary), the amount included in the standard of need, and the payment standard, applied to such child or relative for shelter, utilities, and similar needs may be prorated on a reasonable basis, in such manner and under such circumstances as the State may determine to be appropriate. For purposes of any method of proration used by a State under this section, there shall not be included as a member of a household an individual receiving benefits under title XVI in any month to whom the one-third reduction prescribed by section 1612(a)(2)(A)(i) is applied.

TECHNICAL ASSISTANCE FOR DEVELOPING MANAGEMENT INFORMATION SYSTEMS

SEC. 413. [42 U.S.C. 613] The Secretary shall provide such technical assistance to States as he determines necessary to assist States to plan, design, develop, or install and provide for the security of, the management information systems referred to in section 403(a)(3)(B) of this Act.

[SEC. 414. Repealed.[129]]

ATTRIBUTION OF SPONSOR'S INCOME AND RESOURCES TO ALIEN

SEC. 415. [42 U.S.C. 615] (a) For purposes of determining eligibility for and the amount of benefits under a State plan approved under this part for an individual who is an alien described in clause (B) of section 402(a)(33), the income and resources of any person who (as a sponsor of such individual's entry into the United States) executed an affidavit of support or similar agreement with respect to such individual, and the income and resources of the sponsor's spouse, shall be deemed to be the unearned income and resources of such individual (in accordance with subsections (b) and (c)) for a period of three years after the individual's entry into the United States, except that this section is not applicable if such individual is a dependent child and such sponsor (or such sponsor's spouse) is the parent of such child.

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[128] P.L. 98-369, §2651(b)(3); 98 Stat. 1149.

[129] P.L. 100-485, §202(b)(13), repealed §414. For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1). [For §414 as it reads until then, see Vol. III, P.L. 100-485.]

(b)(1) The amount of income of a sponsor (and his spouse) which shall be deemed to be the unearned income of an alien for any month shall be determined as follows:

(A) the total amount of earned and unearned income of such sponsor and such sponsor's spouse (if such spouse is living with the sponsor) shall be determined for such month;

(B) the amount determined under subparagraph (A) shall be reduced by an amount equal to the sum of—

(i) the lesser of (I) 20 percent of the total of any amounts received by the sponsor and his spouse in such month as wages or salary or as net earnings from self-employment, plus the full amount of any costs incurred by them in producing self-employment income in such month, or (II) $175;

(ii) the cash needs standard established by the State under its plan for a family of the same size and composition as the sponsor and those other individuals living in the same household as the sponsor who are claimed by him as dependents for purposes of determining his Federal personal income tax liability but whose needs are not taken into account in making a determination under section 402(a)(7);

(iii) any amounts paid by the sponsor (or his spouse) to individuals not living in such household who are claimed by him as dependents for purposes of determining his Federal personal income tax liability; and

(iv) any payments of alimony or child support with respect to individuals not living in such household.

(2) The amount of resources of a sponsor (and his spouse) which shall be deemed to be the resources of an alien for any month shall be determined as follows:

(A) the total amount of the resources (determined as if the sponsor were applying for aid under the State plan approved under this part) of such sponsor and such sponsor's spouse (if such spouse is living with the sponsor) shall be determined; and

(B) the amount determined under subparagraph (A) shall be reduced by $1,500.

(c)(1) Any individual who is an alien and whose sponsor was a public or private agency shall be ineligible for aid under a State plan approved under this part during the period of three years after his or her entry into the United States, unless the State agency administering such plan determines that such sponsor either no longer exists or has become unable to meet such individual's needs; and such determination shall be made by the State agency based upon such criteria as it may specify in the State plan, and upon such documentary evidence as it may therein require. Any such individual, and any other individual who is an alien (as a condition of his or her eligibility for aid under a State plan approved under this part during the period of three years after his or her entry into the United States), shall be required to provide to the State agency administering such plan such information and documentation with respect to his sponsor as may be necessary in order for the State agency to make any determination required under this section, and to obtain any cooperation from such sponsor necessary for any such determination. Such alien shall also be required to provide to the State agency such information and documentation as it may request and which such alien or his sponsor provided in support of such alien's immigration application.

(2) The Secretary shall enter into agreements with the Secretary of State and the Attorney General whereby any information available to them and required in order to make any determination under this section will be provided by them to the Secretary (who may, in turn, make such information available, upon request, to a concerned State agency), and whereby the Secretary of State and Attorney General will inform any sponsor of an alien, at the time such sponsor executes an affidavit of support or similar agreement, of the requirements imposed by this section.

(d) Any sponsor of an alien, and such alien, shall be jointly and severally liable for an amount equal to any overpayment of aid under the State plan made to such alien during the period of three years after such alien's entry into the United States, on account of such sponsor's failure to provide correct information under the provisions of this section, except where such sponsor was without fault, or where good cause of such failure existed. Any such overpayment which is not repaid to the State or recovered in accordance with the procedures generally applicable under the State plan to the recoupment of overpayments shall be withheld from any subsequent payment to which such alien or such sponsor is entitled under any provision of this Act.

(e)(1) In any case where a person is the sponsor of two or more alien individuals who are living in the same home, the income and resources of such sponsor (and his spouse), to the extent they would be deemed the income and resources of any one of such individuals under the preceding provisions of this section, shall be divided into two or more equal shares (the number of shares being the same as the number of such alien individuals) and the income and resources of each such individual shall be deemed to include one such share.

(2) Income and resources of a sponsor (and his spouse) which are deemed under this section to be the income and resources of any alien individual in a family shall not be considered in determining the need of other family members except to the extent such income or resources are actually available to such other members.

(f) The provisions of this section shall not apply with respect to any alien who is—

(1) admitted to the United States as a result of the application, prior to April 1, 1980, of the provisions of section 203(a)(7) of the Immigration and Nationality Act[130];

(2) admitted to the United States as a result of the application, after March 31, 1980, of the provisions of section 207(c) of such Act;

(3) paroled into the United States as a refugee under section 212(d)(5) of such Act;

(4) granted political asylum by the Attorney General under section 208 of such Act; or

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[130] P.L. 82-414.

(5) a Cuban and Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Public Law 96-422).

FRAUD CONTROL

SEC. 416. [42 U.S.C. 616] (a) Any State, in the administration of its State plan approved under section 402, may elect to establish and operate a fraud control program in accordance with this section.

(b) Under any such program, if an individual who is a member of a family applying for or receiving aid under the State plan approved under section 402 is found by a Federal or State court or pursuant to an administrative hearing meeting requirements determined in regulations of the Secretary, on the basis of a plea of guilty or nolo contendere or otherwise, to have intentionally—

(1) made a false or misleading statement or misrepresented, concealed, or withheld facts, or

(2) committed any act intended to mislead, misrepresent, conceal, or withhold facts or propound a falsity,

for the purpose of establishing or maintaining the family's eligibility for aid under such State plan or of increasing (or preventing a reduction in) the amount of such aid, then the needs of such individual shall not be taken into account in making the determination under section 402(a)(7) with respect to his or her family (A) for a period of 6 months upon the first occasion of any such offense, (B) for a period of 12 months upon the second occasion of any such offense, and (C) permanently upon the third or a subsequent occasion of any such offense.

(c) The State agency involved shall proceed against any individual alleged to have committed an offense described in subsection (b) either by way of administrative hearing or by referring the matter to the appropriate authorities for civil or criminal action in a court of law. The State agency shall coordinate its actions under this section with any corresponding actions being taken under the food stamp program in any case where the factual issues involved arise from the same or related circumstances.

(d) Any period for which sanctions are imposed under subsection (b) shall remain in effect, without possibility of administrative stay, unless and until the finding upon which the sanctions were imposed is subsequently reversed by a court of appropriate jurisdiction; but in no event shall the duration of the period for which such sanctions are imposed be subject to review.

(e) The sanctions provided under subsection (b) shall be in addition to, and not in substitution for, any other sanctions which may be provided for by law with respect to the offenses involved.

(f) Each State which has elected to establish and operate a fraud control program under this section must provide all applicants for aid to families with dependent children under its approved State plan, at the time of their application for such aid, with a written notice of the penalties for fraud which are provided for under this section.

ASSISTANT SECRETARY FOR FAMILY SUPPORT[131]

SEC. 417. [42 U.S.C. 617] The programs under this part, part D, and part F shall be administered by an Assistant Secretary for Family Support within the Department of Health and Human Services, who shall be appointed by the President, by and with the advice and consent of the Senate, and who shall be in addition to any other Assistant Secretary of Health and Human Services provided for by law.

PART B—CHILD WELFARE SERVICES[132]

APPROPRIATION

SEC. 420. [42 U.S.C. 620] (a) For the purpose of enabling the United States, through the Secretary, to cooperate with State public welfare agencies in establishing, extending, and strengthening child welfare services, there is authorized to be appropriated for each fiscal year the sum of $325,000,000[133].

(b) Funds appropriated for any fiscal year pursuant to the authorization contained in subsection (a) shall be included in the appropriation Act (or supplemental appropriation Act) for the fiscal year preceding the fiscal year for which such funds are available for obligation. In order to effect a transition to this method of timing appropriation action, the preceding sentence shall apply notwithstanding the fact that its initial application will result in the enactment in the same year (whether in the same appropriation Act or otherwise) of two separate appropriations, one for the then current fiscal year and one for the succeeding fiscal year.

ALLOTMENTS TO STATES

SEC. 421. [42 U.S.C. 621] (a) The sum appropriated pursuant to section 420 for each fiscal year shall be allotted by the Secretary for use by cooperating State public welfare agencies which have plans developed jointly by the State agency and the Secretary as follows: He shall first allot $70,000 to each State, and shall then allot to each State an amount which bears the same ratio to the remainder of such sum as the product of (1) the population of the State under the age of twenty-one and (2) the allotment percentage of the State (as determined under this section) bears to the sum of the corresponding products of all the States.

(b) The "allotment percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be the percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the United States; except that (1) the allotment percentage shall in no case be less than 30 per centum or more than 70 per centum, and (2) the allotment percentage shall be 70 per centum in the case of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

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[131] P.L. 100-485, §603(a), added §418, effective February 1, 1989.

P.L. 100-647, §8105(7), redesignated §418 as §417, effective as if included in the enactment of P.L. 100-485, §603(a).

[132] See Vol. II, P.L. 93-288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 95-608, §201(b), with respect to Indian child welfare.

See Vol. II, P.L. 100-139, §4(h)(6), with respect to exclusion of benefits as basis for denial of eligibility.

See Vol. II, P.L. 100-407, §105(c), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100-409, §5, with respect to the effect of this Act on P.L. 92-203 or P.L. 96-487.

See Vol. II, P.L. 100-411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100-581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

[133] P.L. 101-239, §10401(a), struck out "$266,000,000" and substituted "$325,000,000", effective October 1, 1989.

(c) The allotment percentage for each State shall be promulgated by the Secretary between October 1 and November 30 of each even-numbered year, on the basis of the average per capita income of each State and of the United States for the three most recent calendar years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning October 1 next succeeding such promulgation.

(d) For purposes of this section, the term "United States" means the fifty States and the District of Columbia.

STATE PLANS FOR CHILD WELFARE SERVICES[134]

SEC. 422. [42 U.S.C. 622] (a) In order to be eligible for payment under this part, a State must have a plan for child welfare services which has been developed jointly by the Secretary and the State agency designated pursuant to subsection (b)(1), and which meets the requirements of subsection (b).

(b) Each plan for child welfare services under this part shall—

(1) provide that (A) the individual or agency that administers or supervises the administration of the State's services program under title XX[135] will administer or supervise the administration of the plan (except as otherwise provided in section 103(d) of the Adoption Assistance and Child Welfare Act of 1980[136]), and (B) to the extent that child welfare services are furnished by the staff of the State agency or local agency administering the plan, a single organizational unit in such State or local agency, as the case may be, will be responsible for furnishing such child welfare services;

(2) provide for coordination between the services provided for children under the plan and the services and assistance provided under title XX, under the State plan approved under part A of this title, under the State plan approved under part E of this title, and under other State programs having a relationship to the program under this part, with a view to provision of welfare and related services which will best promote the welfare of such children and their families;

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[134] P.L. 96-272, §103(a), amended §422 in its entirety effective June 17, 1980, except that in the case of Guam, Puerto Rico, the Virgin Islands, and the Commonwealth of the Northern Mariana Islands, §422(b)(1) shall be deemed to read as follows:

> "(1) provide that (A) the State agency designated pursuant to section 402(a)(3) to administer or supervise the administration of the plan of the State approved under part A of this title will administer or supervise the administration of such plan for child welfare services, and (B) to the extent that child welfare services are furnished by the staff of the State agency or local agency administering such plan for child welfare services, the organizational unit in such State or local agency established pursuant to section 402(a)(15) will be responsible for furnishing such child welfare services;".

[135] P.L. 101-239, §10403(b)(1), struck out "the individual or agency designated pursuant to section 2003(d)(1)(C) to administer or supervise the administration of the State's services program" and substituted "the individual or agency that administers or supervises the administration of the State's services program under title XX", applicable as if included in the enactment of P.L. 99-514, §1883(e)(1), effective October 22, 1986.

[136] P.L. 96-272.

(3) provide that the standards and requirements imposed with respect to child day care under title XX shall apply with respect to day care services under this part, except insofar as eligibility for such services is involved;

(4) provide for the training and effective use of paid paraprofessional staff, with particular emphasis on the full-time or part-time employment of persons of low income, as community service aides, in the administration of the plan, and for the use of nonpaid or partially paid volunteers in providing services and in assisting any advisory committees established by the State agency;

(5) contain a description of the services to be provided and specify the geographic areas where such services will be available;

(6) contain a description of the steps which the State will take to provide child welfare services and to make progress in—

(A) covering additional political subdivisions,

(B) reaching additional children in need of services, and

(C) expanding and strengthening the range of existing services and developing new types of services,

along with a description of the State's child welfare services staff development and training plans;

(7) provide, in the development of services for children, for utilization of the facilities and experience of voluntary agencies in accordance with State and local programs and arrangements, as authorized by the State; and

(8) provide that the agency administering or supervising the administration of the plan will furnish such reports, containing such information, and participate in such evaluations, as the Secretary may require.

PAYMENT TO STATES

SEC. 423. [42 U.S.C. 623] (a) From the sums appropriated therefor and the allotment under this part, subject to the conditions set forth in this section and in section 427, the Secretary shall from time to time pay to each State that has a plan developed in accordance with section 422 an amount equal to 75 per centum of the total sum expended under the plan (including the cost of administration of the plan) in meeting the costs of State, district, county, or other local child welfare services.

(b) The method of computing and making payments under this section shall be as follows:

(1) The Secretary shall, prior to the beginning of each period for which a payment is to be made, estimate the amount to be paid to the State for such period under the provisions of this section.

(2) From the allotment available therefor, the Secretary shall pay the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this section) by which he finds that his estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid to the State for such prior period under this section.

(c)(1) No payment may be made to a State under this part, for any fiscal year beginning after September 30, 1979, with respect to State expenditures made for (A) child day care necessary solely because of the employment, or training to prepare for employment, of a parent or other relative with whom the child involved is living, (B) foster care maintenance payments, and (C) adoption assistance payments, to the extent that the Federal payment with respect to those expenditures would exceed the total amount of the Federal payment under this part for fiscal year 1979.

(2) Expenditures made by a State for any fiscal year which begins after September 30, 1979, for foster care maintenance payments shall be treated for purposes of making Federal payments under this part with respect to expenditures for child welfare services, as if such foster care maintenance payments constituted child welfare services of a type to which the limitation imposed by paragraph (1) does not apply; except that the amount payable to the State with respect to expenditures made for other child welfare services and for foster care maintenance payments during any such year shall not exceed 100 per centum of the amount of the expenditures made for child welfare services for which payment may be made under the limitation imposed by paragraph (1) as in effect without regard to this paragraph.

(d) No payment may be made to a State under this part in excess of the payment made under this part for fiscal year 1979, for any fiscal year beginning after September 30, 1979, if for the latter fiscal year the total of the State's expenditures for child welfare services under this part (excluding expenditures for activities specified in subsection (c)(1)) is less than the total of the State's expenditures under this part (excluding expenditures for such activities) for fiscal year 1979.

REALLOTMENT

SEC. 424. [42 U.S.C. 624] The amount of any allotment to a State under section 421 for any fiscal year which the State certifies to the Secretary will not be required for carrying out the State plan developed as provided in section 422 shall be available for reallotment from time to time, on such dates as the Secretary may fix, to other States which the Secretary determines (1) have need in carrying out their State plans so developed for sums in excess of those previously allotted to them under section 421 and (2) will be able to use such excess amounts during such fiscal year. Such reallotments shall be made on the basis of the State plans so developed, after taking into consideration the population under the age of twenty-one, and the per capita income of each such State as compared with the population under the age of twenty-one, and the per capita income of all such States with respect to which such a determination by the Secretary has been made. Any amount so reallotted to a State shall be deemed part of its allotment under section 421.

DEFINITIONS

SEC. 425. [42 U.S.C. 625] (a)(1) For purposes of this title, the term "child welfare services" means public social services which are directed toward the accomplishment of the following purposes: (A) protecting and promoting the welfare of all children, including handicapped, homeless, dependent, or neglected children; (B) preventing or remedying, or assisting in the solution of problems which may result in, the neglect, abuse, exploitation, or delinquency of children; (C) preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing breakup of the family where the prevention of child removal is desirable and possible; (D) restoring to their families children who have been removed, by the provision of services to the child and the families; (E) placing children in suitable adoptive homes, in cases where restoration to the biological family is not possible or appropriate; and (F) assuring adequate care of children away from their homes, in cases where the child cannot be returned home or cannot be placed for adoption.

(2) Funds expended by a State for any calendar quarter to comply with the statistical report required by section 476(b), and funds expended with respect to nonrecurring costs of adoption proceedings in the case of children placed for adoption with respect to whom assistance is provided under a State plan for adoption assistance approved under part E of this title, shall be deemed to have been expended for child welfare services.

(b) For other definitions relating to this part and to part E of this title, see section 475 of this Act.

RESEARCH, TRAINING, OR DEMONSTRATION PROJECTS[137]

SEC. 426. [42 U.S.C. 626] (a) There are hereby authorized to be appropriated for each fiscal year such sums as the Congress may determine—

(1) for grants by the Secretary—

(A) to public or other nonprofit institutions of higher learning, and to public or other nonprofit agencies and organizations engaged in research or child-welfare activities, for special research or demonstration projects in the field of child welfare which are of regional or national significance and for special projects for the demonstration of new methods or facilities which show promise of substantial contribution to the advancement of child welfare;

(B) to State or local public agencies responsible for administering, or supervising the administration of, the plan under this part, for projects for the demonstration of the utilization of research (including findings resulting therefrom) in the field of child welfare in order to encourage experimental and special types of welfare services; and

(C) to public or other nonprofit institutions of higher learning for special projects for training personnel for work in the field of child welfare, including traineeships with such stipends and allowances as may be permitted by the Secretary; and

(2) for contracts or jointly financed cooperative arrangements with States and public and other organizations and agencies for the conduct of research, special projects, or demonstration projects relating to such matters.

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[137] See Vol. II, P.L. 100-77, §761, with respect to a study of youth homelessness.

(b)(1) There are authorized to be appropriated $4,000,000 for each of the fiscal years 1988, 1989, and 1990 for grants by the Secretary to public or private nonprofit entities submitting applications under this subsection for the purpose of conducting demonstration projects under this subsection to develop alternative care arrangements for infants who do not have health conditions that require hospitalization and who would otherwise remain in inappropriate hospital settings.

(2) The demonstration projects conducted under this section may include—

(A) multidisciplinary projects designed to prevent the inappropriate hospitalization of infants and to allow infants described in paragraph (1) to remain with or return to a parent in a residential setting, where appropriate care for the infant and suitable treatment for the parent (including treatment for drug or alcohol addiction) may be assured, with the goal (where possible) of rehabilitating the parent and eliminating the need for such care for the infant;

(B) multidisciplinary projects that assure appropriate, individualized care for such infants in a foster home or other non-medical residential setting in cases where such infant does not require hospitalization and would otherwise remain in inappropriate hospital settings, including projects to demonstrate methods to recruit, train, and retain foster care families; and

(C) such other projects as the Secretary determines will best serve the interests of such infants and will serve as models for projects that agencies or organizations in other communities may wish to develop.

(3) In the case of any project which includes the use of funds authorized under this subsection for the care of infants in foster homes or other non-medical residential settings away from their parents, there shall be developed for each such infant a case plan of the type described in section 475(1) (to the extent that such infant is not otherwise covered by such a plan), and each such project shall include a case review system of the type described in section 475(5) (covering each such infant who is not otherwise subject to such a system).

(4) In evaluating applications from entities proposing to conduct demonstration projects under this subsection, the Secretary shall give priority to those projects that serve areas most in need of alternative care arrangements for infants described in paragraph (1).

(5) No project may be funded unless the application therefor contains assurances that it will—

(A) provide for adequate evaluation;

(B) provide for coordination with local governments;

(C) provide for community education regarding the inappropriate hospitalization of infants;

(D) use, to the extent practical, other available private, local, State, and Federal sources for the provision of direct services; and

(E) meet such other criteria as the Secretary may prescribe.

(6) Grants may be used to pay the costs of maintenance and of necessary medical and social services (to the extent that these costs are not otherwise paid for under other titles of this Act), and for such other purposes as the Secretary may allow.

(7) The Secretary shall provide training and technical assistance to grantees, as requested.

(c) Payments of grants or under contracts or cooperative arrangements under this section may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine; and shall be made on such conditions as the Secretary finds necessary to carry out the purposes of the grants, contracts, or other arrangements.

FOSTER CARE PROTECTION REQUIRED FOR ADDITIONAL FEDERAL PAYMENTS

SEC. 427. [42 U.S.C. 627] (a) If, for any fiscal year after fiscal year 1979, there is appropriated under section 420 a sum in excess of $141,000,000, a State shall not be eligible for payment from its allotment in an amount greater than the amount for which it would be eligible if such appropriation were equal to $141,000,000, unless such State—

(1) has conducted an inventory of all children who have been in foster care under the responsibility of the State for a period of six months preceding the inventory, and determined the appropriateness of, and necessity for, the current foster placement, whether the child can be or should be returned to his parents or should be freed for adoption, and the services necessary to facilitate either the return of the child or the placement of the child for adoption or legal guardianship; and

(2) has implemented and is operating to the satisfaction of the Secretary—

(A) a statewide information system from which the status, demographic characteristics, location, and goals for the placement of every child in foster care or who has been in such care within the preceding twelve months can readily be determined;

(B) a case review system (as defined in section 475(5)) for each child receiving foster care under the supervision of the State; and

(C) a service program designed to help children, where appropriate, return to families from which they have been removed or be placed for adoption or legal guardianship.

(b) If, for each of any two consecutive fiscal years after the fiscal year 1979, there is appropriated under section 420 a sum equal to $325,000,000[138], each State's allotment amount for any fiscal year after such two consecutive fiscal years shall be reduced to an amount equal to its allotment amount for the fiscal year 1979, unless such State—

(1) has completed an inventory of the type specified in subsection (a)(1);

(2) has implemented and is operating the program and systems specified in subsection (a)(2); and

(3) has implemented a preplacement preventive service program designed to help children remain with their families.

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[138] P.L. 101-239, §10401(a), struck out "$266,000,000" and substituted "$325,000,000", effective October 1, 1989.

(c) Any amounts expended by a State for the purpose of complying with the requirements of subsection (a) or (b) shall be conclusively presumed to have been expended for child welfare services.

PAYMENTS TO INDIAN TRIBAL ORGANIZATIONS[139]

SEC. 428. [42 U.S.C. 628] (a) The Secretary may, in appropriate cases (as determined by the Secretary) make payments under this part directly to an Indian tribal organization within any State which has a plan for child welfare services approved under this part. Such payments shall be made in such manner and in such amounts as the Secretary determines to be appropriate.

(b) Amounts paid under subsection (a) shall be deemed to be a part of the allotment (as determined under section 421) for the State in which such Indian tribal organization is located.

(c) For purposes of this section—

(1) the term "tribal organization" means the recognized governing body of any Indian tribe, or any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body; and

(2) the term "Indian tribe" means any tribe, band, nation, or other organized group or community of Indians (including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (Public Law 92-203; 85 Stat. 688)) which (A) is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians, or (B) is located on, or in proximity to, a Federal or State reservation or rancheria.

[PART C—§§430-445. Repealed.[140]]

PART D—CHILD SUPPORT AND ESTABLISHMENT OF PATERNITY[141]

APPROPRIATION

SEC. 451. [42 U.S.C. 651] For the purpose of enforcing the support obligations owed by absent parents to their children and the spouse (or former spouse) with whom such children are living, locating absent parents, establishing paternity, obtaining child and spousal support, and assuring that assistance in obtaining support will be available under this part to all children (whether or not eligible for aid under part A) for whom such assistance is requested, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this part.

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[139] See Vol. II, P.L. 93-288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 100-407, §105(c), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100-409, §5, with respect to the effect of this Act on P.L. 92-203 or P.L. 96-487.

See Vol. II, P.L. 100-411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100-581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

[140] P.L. 100-485, §202(a), repealed part C of title IV. For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1). [For part C of title IV (§§430-445) as it reads until then, see Vol. III, P.L. 100-485.]

[141] See Vol. II, P.L. 73-30, §3, for the requirement that State employment offices supply data in aid of administration of the Aid to Families With Dependent Children and child support programs.

See Vol. II, P.L. 83-591, §6103(l)(1), with respect to disclosure of returns and return information by the Secretary of the Treasury to the Social Security Administration, and §7213(a)(1) with respect to the penalty for unauthorized disclosure of that tax return information.

See Vol. II, P.L. 95-630, §§1101-1121, with respect to an individual's right to financial privacy.

See Vol. II, P.L. 98-378, §22, with respect to the Wisconsin Child Support Initiative.

See Vol. II, P.L. 99-177, §256 , with respect to treatment of the child support enforcement program.

DUTIES OF THE SECRETARY

SEC. 452. [42 U.S.C. 652] (a) The Secretary shall establish, within the Department of Health and Human Services a separate organizational unit, under the direction of a designee of the Secretary, who shall report directly to the Secretary and who shall—

(1) establish such standards for State programs for locating absent parents, establishing paternity, and obtaining child support and support for the spouse (or former spouse) with whom the absent parent's child is living as he determines to be necessary to assure that such programs will be effective;

(2) establish minimum organizational and staffing requirements for State units engaged in carrying out such programs under plans approved under this part;

(3) review and approve State plans for such programs;

(4) evaluate the implementation of State programs established pursuant to such plan, conduct such audits of State programs established under the plan approved under this part as may be necessary to assure their conformity with the requirements of this part, and, not less often than once every three years (or not less often than annually in the case of any State to which a reduction is being applied under section 403(h)(1), or which is operating under a corrective action plan in accordance with section 403(h)(2)), conduct a complete audit of the programs established under such plan in each State and determine for the purposes of the penalty provision of section 403(h) whether the actual operation of such programs in each State conforms to the requirements of this part;

(5) assist States in establishing adequate reporting procedures and maintain records of the operations of programs established pursuant to this part in each State;

(6) maintain records of all amounts collected and disbursed under programs established pursuant to the provisions of this part and of the costs incurred in collecting such amounts;

(7) provide technical assistance to the States to help them establish effective systems for collecting child and spousal support and establishing paternity;

(8) receive applications from States for permission to utilize the courts of the United States to enforce court orders for support against absent parents and, upon a finding that (A) another State has not undertaken to enforce the court order of the originating State against the absent parent within a reasonable time, and (B) that utilization of the Federal courts is the only reasonable method of enforcing such order, approve such applications;

(9) operate the Parent Locator Service established by section 453; and

(10) not later than three months after the end of each fiscal year, beginning with the year 1977, submit to the Congress a full and complete report on all activities undertaken pursuant to the

provisions of this part, which report shall include, but not be limited to, the following:

(A) total program costs and collections set forth in sufficient detail to show the cost to the States and the Federal Government, the distribution of collections to families, State and local governmental units, and the Federal Government; and an identification of the financial impact of the provisions of this part;

(B) costs and staff associated with the Office of Child Support Enforcement;

(C) the following data, with the data required under each clause being separately stated for cases where the child is receiving aid to families with dependent children (or foster care maintenance payments under part E), cases where the child was formerly receiving such aid or payments and the State is continuing to collect support assigned to it under section 402(a)(26) or 471(a)(17), and all other cases under this part:

(i) the total number of cases in which a support obligation has been established in the fiscal year for which the report is submitted, and the total amount of such obligations;

(ii) the total number of cases in which a support obligation has been established, and the total amount of such obligations;

(iii) the number of cases described in clause (i) in which support was collected during such fiscal year, and the total amount of such collections;

(iv) the number of cases described in clause (ii) in which support was collected during such fiscal year, and the total amount of such collections; and

(v) the number of child support cases filed in each State in such fiscal year, and the amount of the collections made in each State in such fiscal year, on behalf of children residing in another State or against parents residing in another State;

(D) the status of all State plans under this part as of the end of the fiscal year last ending before the report is submitted, together with an explanation of any problems which are delaying or preventing approval of State plans under this part;

(E) data, by State, on the use of the Federal Parent Locator Service, and the number of locate requests submitted without the absent parent's social security account number;

(F) the number of cases, by State, in which an applicant for or recipient of aid under a State plan approved under part A has refused to cooperate in identifying and locating the absent parent and the number of cases in which refusal so to cooperate is based on good cause (as determined in accordance with the standards referred to in section 402(a)(26)(B)(ii));

(G) data, by State, on the use of Federal courts and on use of the Internal Revenue Service for collections, the number of court orders on which collections were made, the number of paternity determinations made and the number of parents located, in sufficient detail to show the cost and benefits to the States and to the Federal Government;

(H) the major problems encountered which have delayed or prevented implementation of the provisions of this part during the fiscal year last ending prior to the submission of such report; and

(I) the amount of administrative costs which are expended in each functional category of expenditures, including establishment of paternity.

The information contained in any such report under subparagraph (A) shall specifically include (i) the total amount of child support payments collected as a result of services furnished during the fiscal year involved to individuals under section 454(6), (ii) the cost to the States and to the Federal Government of furnishing such services to those individuals, and (iii) the extent to which the furnishing of such services was successful in providing sufficient support to those individuals to assure that they did not require assistance under the State plan approved under part A.

(b) The Secretary shall, upon the request of any State having in effect a State plan approved under this part, certify to the Secretary of the Treasury for collection pursuant to the provisions of section 6305 of the Internal Revenue Code of 1954[142] the amount of any child support obligation (including any support obligation with respect to the parent who is living with the child and receiving aid under the State plan approved under part A) which is assigned to such State or is undertaken to be collected by such State pursuant to section 454(6). No amount may be certified for collection under this subsection except the amount of the delinquency under a court or administrative order for support and upon a showing by the State that such State has made diligent and reasonable efforts to collect such amounts utilizing its own collection mechanisms, and upon an agreement that the State will reimburse the Secretary of the Treasury for any costs involved in making the collection. All reimbursements shall be credited to the appropriation accounts which bore all or part of the costs involved in making the collections. The Secretary after consultation with the Secretary of the Treasury may, by regulation, establish criteria for accepting amounts for collection and for making certification under this subsection including imposing such limitations on the frequency of making such certifications under this subsection.

(c) The Secretary of the Treasury shall from time to time pay to each State for distribution in accordance with the provisions of section 457 the amount of each collection made on behalf of such State pursuant to subsection (b).

(d)(1) Except as provided in paragraph (3), the Secretary shall not approve the initial and annually updated advance automated data processing planning document, referred to in section 454(16), unless he finds that such document, when implemented, will generally carry out the objectives of the management system referred to in such subsection, and such document—

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[142] P.L. 83-591.

(A) provides for the conduct of, and reflects the results of, requirements analysis studies, which include consideration of the program mission, functions, organization, services, constraints, and current support, of, in, or relating to, such system,

(B) contains a description of the proposed management system referred to in section 455(a)(1)(B), including a description of information flows, input data, and output reports and uses,

(C) sets forth the security and interface requirements to be employed in such management system,

(D) describes the projected resource requirements for staff and other needs, and the resources available or expected to be available to meet such requirements,

(E) contains an implementation plan and backup procedures to handle possible failures,

(F) contains a summary of proposed improvement of such management system in terms of qualitative and quantitative benefits, and

(G) provides such other information as the Secretary determines under regulation is necessary.

(2)(A) The Secretary shall through the separate organizational unit established pursuant to subsection (a), on a continuing basis, review, assess, and inspect the planning, design, and operation of, management information systems referred to in section 455(a)(1)(B), with a view to determining whether, and to what extent, such systems meet and continue to meet requirements imposed under paragraph (1) and the conditions specified under section 454(16).

(B) If the Secretary finds with respect to any statewide management information system referred to in section 455(a)(1)(B) that there is a failure substantially to comply with criteria, requirements, and other undertakings, prescribed by the advance automated[143] data processing planning document theretofore approved by the Secretary with respect to such system, then the Secretary shall suspend his approval of such document until there is no longer any such failure of such system to comply with such criteria, requirements, and other undertakings so prescribed.

(3) The Secretary may waive any requirement of paragraph (1) or any condition specified under section 454(16) with respect to a State if—

(A) the State demonstrates to the satisfaction of the Secretary that the State has an alternative system or systems that enable the State, for purposes of section 403(h), to be in substantial compliance with other requirements of this part; and

(B)(i) the waiver meets the criteria of paragraphs (1), (2), and (3) of section 1115(c), or

(ii) the State provides assurances to the Secretary that steps will be taken to otherwise improve the State's child support enforcement program.

(e) The Secretary shall provide such technical assistance to States as he determines necessary to assist States to plan, design, develop, or install and provide for the security of, the management information systems referred to in section 455(a)(1)(B).

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[143] P.L 101-239, §10403(a)(1)(B)(i), struck out "automatic" and substituted "automated", effective October 13, 1988.

(f) The Secretary shall issue regulations to require that State agencies administering the child support enforcement program under this part petition for the inclusion of medical support as part of any child support order whenever health care coverage is available to the absent parent at a reasonable cost. Such regulation shall also provide for improved information exchange between such State agencies and the State agencies administering the State medicaid programs under title XIX with respect to the availability of health insurance coverage.

(g)(1) A State's program under this part shall be found, for purposes of section 403(h), not to have complied substantially with the requirements of this part unless, for any fiscal year beginning on or after October 1, 1991, its paternity establishment percentage for such fiscal year equals or exceeds—

(A) 50 percent;

(B) the paternity establishment percentage of the State for the fiscal year 1988, increased by the applicable number of percentage points; or

(C) the paternity establishment percentage determined with respect to all States for such fiscal year.

(2) For purposes of this section—

(A) the term "paternity establishment percentage" means, with respect to a State (or all States, as the case may be) for a fiscal year, the ratio (expressed as a percentage) that the total number of children—

(i) who have been born out of wedlock,

(ii)(I) except as provided in the last sentence of this paragraph, with respect to whom aid is being paid under the State's plan approved under part A (or under all such plans) for such fiscal year, or (II) with respect to whom services are being provided under the State's plan approved under this part (or under all such plans) for the fiscal year pursuant to an application submitted under section 454(6), and

(iii) the paternity of whom has been established,

bears to the total number of children who have been born out of wedlock and (except as provided in such last sentence) with respect to whom aid is being paid under the State's plan approved under part A (or under all such plans) for such fiscal year or with respect to whom services are being provided under the State's plan approved under this part (or under all such plans) for the fiscal year pursuant to an application submitted under section 454(6); and

(B) the applicable number of percentage points means, with respect to a fiscal year (beginning with the fiscal year 1991), 3 percentage points multiplied by the number of fiscal years after the fiscal year 1989 and before the beginning of such fiscal year.

For purposes of subparagraph (A), the total number of children shall not include any child who is a dependent child by reason of the death of a parent or any child with respect to whom an applicant or recipient is found to have good cause for refusing to cooperate under section 402(a)(26).

(3)(A) The requirements of this subsection are in addition to and shall not supplant any other requirement (that is not inconsistent with such requirements) established in regulations by the Secretary for the purpose of determining (for purposes of section 403(h)) whether the program of a State operated under this part shall be treated as complying substantially with the requirements of this part.

(B) The Secretary may modify the requirements of this subsection to take into account such additional variables as the Secretary identifies (including the percentage of children born out-of-wedlock in a State) that affect the ability of a State to meet the requirements of this subsection.

(C) The Secretary shall submit an annual report to the Congress that sets forth the data upon which the paternity establishment percentages for States for a fiscal year are based, lists any additional variables the Secretary has identified under subparagraph (A), and describes State performance in establishing paternity.[144]

(h) The standards required by subsection (a)(1) shall include standards establishing time limits governing the period or periods within which a State must accept and respond to requests (from States, jurisdictions thereof, or individuals who apply for services furnished by the State agency under this part or with respect to whom an assignment under section 402(a)(26) is in effect) for assistance in establishing and enforcing support orders, including requests to locate absent parents, establish paternity, and initiate proceedings to establish and collect child support awards.[145]

(i) The standards required by subsection (a)(1) shall include standards establishing time limits governing the period or periods within which a State must distribute, in accordance with section 457, amounts collected as child support pursuant to the State's plan approved under this part.[146]

PARENT LOCATOR SERVICE

SEC. 453. [42 U.S.C. 653] (a) The Secretary shall establish and conduct a Parent Locator Service, under the direction of the designee of the Secretary referred to in section 452(a), which shall be used to obtain and transmit to any authorized person (as defined in subsection (c)) information as to the whereabouts of any absent parent when such information is to be used to locate such parent for the purpose of enforcing support obligations against such parent.

(b) Upon request, filed in accordance with subsection (d) of any authorized person (as defined in subsection (c)) for the social security account number (or numbers, if the individual involved has more than one such number) and the most recent address and place of employment of any absent parent, the Secretary shall, notwithstanding any other provision of law, provide through the Parent Locator Service such information to such person, if such information—

(1) is contained in any files or records maintained by the Secretary or by the Department of Health and Human Services; or

(2) is not contained in such files or records, but can be obtained by the Secretary, under the authority conferred by subsection (e),

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[144] See Vol. II, P.L. 100-485, §111(f)(3), with respect to the Secretary's collection of data necessary to implement the requirements of this subsection.

[145] See Vol. II, P.L. 100-485, §121(b), with respect to the establishment of an Advisory Committee and regulations.

[146] See Vol. II, P.L. 100-485, §122(b), with respect to issuing regulations regarding those standards.

from any other department, agency, or instrumentality of the United States or of any State.

No information shall be disclosed to any person if the disclosure of such information would contravene the national policy or security interests of the United States or the confidentiality of census data. The Secretary shall give priority to requests made by any authorized person described in subsection (c)(1).

(c) As used in subsection (a), the term "authorized person" means—

(1) any agent or attorney of any State having in effect a plan approved under this part, who has the duty or authority under such plans to seek to recover any amounts owed as child and spousal support (including, when authorized under the State plan, any official of a political subdivision);

(2) the court which has authority to issue an order against an absent parent for the support and maintenance of a child, or any agent of such court; and

(3) the resident parent, legal guardian, attorney, or agent of a child (other than a child receiving aid under part A of this title) (as determined by regulations prescribed by the Secretary) without regard to the existence of a court order against an absent parent who has a duty to support and maintain any such child.

(d) A request for information under this section shall be filed in such manner and form as the Secretary shall by regulation prescribe and shall be accompanied or supported by such documents as the Secretary may determine to be necessary.

(e)(1) Whenever the Secretary receives a request submitted under subsection (b) which he is reasonably satisfied meets the criteria established by subsections (a), (b), and (c), he shall promptly undertake to provide the information requested from the files and records maintained by any of the departments, agencies, or instrumentalities of the United States or of any State.

(2) Notwithstanding any other provision of law, whenever the individual who is the head of any department, agency, or instrumentality of the United States receives a request from the Secretary for information authorized to be provided by the Secretary under this section, such individual shall promptly cause a search to be made of the files and records maintained by such department, agency, or instrumentality with a view to determining whether the information requested is contained in any such files or records. If such search discloses the information requested, such individual shall immediately transmit such information to the Secretary, except that if any information is obtained the disclosure of which would contravene national policy or security interests of the United States or the confidentiality of census data, such information shall not be transmitted and such individual shall immediately notify the Secretary. If such search fails to disclose the information requested, such individual shall immediately so notify the Secretary. The costs incurred by any such department, agency, or instrumentality of the United States or of any State in providing such information to the Secretary shall be reimbursed by him. Whenever such services are furnished to an individual specified in subsection (c)(3), a fee shall be charged such individual. The fee so charged shall be used to reimburse the Secretary or his delegate for the expense of providing such services.

(3) The Secretary of Labor shall enter into an agreement with the Secretary to provide prompt access for the Secretary (in accordance with this subsection) to the wage and unemployment compensation claims information and data maintained by or for the Department of Labor or State employment security agencies.[147]

(f) The Secretary, in carrying out his duties and functions under this section, shall enter into arrangements with State agencies administering State plans approved under this part for such State agencies to accept from resident parents, legal guardians, or agents of a child described in subsection (c)(3) and to transmit to the Secretary requests for information with regard to the whereabouts of absent parents and otherwise to cooperate with the Secretary in carrying out the purposes of this section.

STATE PLAN FOR CHILD AND SPOUSAL SUPPORT[148]

SEC. 454. [42 U.S.C. 654] A State plan for child and spousal support must—

(1) provide that it shall be in effect in all political subdivisions of the State;

(2) provide for financial participation by the State;

(3) provide for the establishment or designation of a single and separate organizational unit, which meets such staffing and organizational requirements as the Secretary may by regulation prescribe, within the State to administer the plan;

(4) provide that such State will undertake—

(A) in the case of a child born out of wedlock with respect to whom an assignment under section 402(a)(26) or section 1912 is effective, to establish the paternity of such child, unless the agency administering the plan of the State under part A of this title determines in accordance with the standards prescribed by the Secretary pursuant to section 402(a)(26)(B) that it is against the best interests of the child to do so, or, in the case of such a child with respect to whom an assignment under section 1912 is in effect, the State agency administering the plan approved under title XIX determines pursuant to section 1912(a)(1)(B) that it is against the best interests of the child to do so, and

(B) in the case of any child with respect to whom such assignment is effective, including an assignment with respect to a child on whose behalf a State agency is making foster care maintenance payments under part E, to secure support for such child from his parent (or from any other person legally liable for such support), and from such parent for his spouse (or former spouse) receiving aid to families with dependent children or medical assistance under a State plan approved under title XIX (but only if a support obligation has been established with respect to such spouse, and only if the support obligation established with respect to the child is being enforced under the plan), utilizing any reciprocal arrangements adopted with other States (unless the agency administering the plan of the State under part A or E of this title determines in accordance with the standards prescribed by the Secretary pursuant to section 402(a)(26)(B) that it is against the best interests of the child to do so), except that when such arrangements and other means have proven ineffective, the State may utilize the Federal courts to obtain or enforce court orders for support;

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[147] P.L. 100-485, §124(a), added paragraph (3), effective January 1, 1990; however, the Secretary and the Secretary of Labor shall enter into the agreement required by this paragraph not later than January 11, 1989.

[148] See Vol. II, P.L. 101-508, §5013, with respect to child support enforcement waiver.

(5) provide that (A) in any case in which support payments are collected for an individual with respect to whom an assignment under section 402(a)(26) is effective, such payments shall be made to the State for distribution pursuant to section 457 and shall not be paid directly to the family, and the individual will be notified on a monthly basis (or on a quarterly basis for so long as the Secretary determines with respect to a State that requiring such notice on a monthly basis would impose an unreasonable administrative burden)[149] of the amount of the support payments collected; except that this paragraph shall not apply to such payments for any month following the first month in which the amount collected is sufficient to make such family ineligible for assistance under the State plan approved under part A; and (B) in any case in which support payments are collected for an individual pursuant to the assignment made under section 1912, such payments shall be made to the State for distribution pursuant to section 1912, except that this clause shall not apply to such payments for any month after the month in which the individual ceases to be eligible for medical assistance;

(6) provide that (A) the child support collection or paternity determination services established under the plan shall be made available to any individual not otherwise eligible for such services upon application filed by such individual with the State, including support collection services for the spouse (or former spouse) with whom the absent parent's child is living (but only if a support obligation has been established with respect to such spouse, and only if the support obligation established with respect to the child is being enforced under the plan), (B) an application fee for furnishing such services shall be imposed, which shall be paid by the individual applying for such services, or recovered from the absent parent, or paid by the State out of its own funds (the payment of which from State funds shall not be considered as an administrative cost of the State for the operation of the plan, and shall be considered income to the program), the amount of which (i) will not exceed $25 (or such higher or lower amount (which shall be uniform for all States) as the Secretary may determine to be appropriate for any fiscal year to reflect increases or decreases in administrative costs), and (ii) may vary among such individuals on the basis of ability to pay (as determined by the State), (C) a fee of not more than $25 may be imposed in any case where the State requests the Secretary of the Treasury to withhold past-due support owed to or on behalf of such individual from a tax refund pursuant to

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[149] P.L. 100-485, §104(a), struck out "at least annually" and substituted "on a monthly basis (or on a quarterly basis for so long as the Secretary determines with respect to a State that requiring such notice on a monthly basis would impose an unreasonable administrative burden)", effective January 1, 1993.

section 464(a)(2), (D) a fee (in accordance with regulations of the Secretary) for performing genetic tests may be imposed on any individual who is not a recipient of aid under a State plan approved under part A,[150] and (E)[151] any costs in excess of the fees so imposed may be collected—

(i) from the parent who owes the child or spousal support obligation involved, or

(ii) at the option of the State, from the individual to whom such services are made available, but only if such State has in effect a procedure whereby all persons in such State having authority to order child or spousal support are informed that such costs are to be collected from the individual to whom such services were made available;[152]

(7) provide for entering into cooperative arrangements with appropriate courts and law enforcement officials (A) to assist the agency administering the plan, including the entering into of financial arrangements with such courts and officials in order to assure optimum results under such program, and (B) with respect to any other matters of common concern to such courts or officials and the agency administering the plan;

(8) provide that the agency administering the plan will establish a service to locate absent parents utilizing—

(A) all sources of information and available records, and

(B) the Parent Locator Service in the Department of Health and Human Services;[153]

(9) provide that the State will, in accordance with standards prescribed by the Secretary, cooperate with any other State—

(A) in establishing paternity, if necessary,

(B) in locating an absent parent residing in the State (whether or not permanently) against whom any action is being taken under a program established under a plan approved under this part in another State,

(C) in securing compliance by an absent parent residing in such State (whether or not permanently) with an order issued by a court of competent jurisdiction against such parent for the support and maintenance of the child or children or the parent of such child or children with respect to whom aid is being provided under the plan of such other State, and

(D) in carrying out other functions required under a plan approved under this part;

(10) provide that the State will maintain a full record of collections and disbursements made under the plan and have an adequate reporting system;

(11) provide that amounts collected as support shall be distributed as provided in section 457;

(12) provide that any payment required to be made under section 456 or 457 to a family shall be made to the resident parent, legal guardian, or caretaker relative having custody of or responsibility for the child or children;

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[150] P.L. 100-485, §111(c)(2), added this subparagraph (D), effective November 1, 1989.

[151] P.L. 100-485, §111(c)(1), redesignated the former subparagraph (D) as subparagraph (E).

[152] See Vol. II, 31 U.S.C. 9701, with respect to fees and charges for Government services and things of value.

[153] See Vol. II, P.L. 83-591, §6103(l)(6), with respect to disclosure to child support enforcement agencies.

(13) provide that the State will comply with such other requirements and standards as the Secretary determines to be necessary to the establishment of an effective program for locating absent parents, establishing paternity, obtaining support orders, and collecting support payments;

(14) comply with such bonding requirements, for employees who receive, disburse, handle, or have access to, cash, as the Secretary shall by regulations prescribe;[154]

(15) maintain methods of administration which are designed to assure that persons responsible for handling cash receipts shall not participate in accounting or operating functions which would permit them to conceal in the accounting records the misuse of cash receipts (except that the Secretary shall by regulations provide for exceptions to this requirement in the case of sparsely populated areas where the hiring of unreasonable additional staff would otherwise be necessary);

(16) provide, at the option of the State, for the establishment, in accordance with an (initial and annually updated) advance automated data processing planning document approved under section 452(d), of a statewide automated data processing and information retrieval system designed effectively and efficiently to assist management in the administration of the State plan, in the State and localities thereof, so as (A) to control, account for, and monitor (i) all the factors in the support enforcement collection and paternity determination process under such plan (including, but not limited to, (I) identifiable correlation factors (such as social security numbers, names, dates of birth, home addresses and mailing addresses (including postal ZIP codes) of any individual with respect to whom support obligations are sought to be established or enforced and with respect to any person to whom such support obligations are owing) to assure sufficient compatibility among the systems of different jurisdictions to permit periodic screening to determine whether such individual is paying or is obligated to pay support in more than one jurisdiction, (II) checking of records of such individuals on a periodic basis with Federal, intra- and inter-State, and local agencies, (III) maintaining the data necessary to meet the Federal reporting requirements on a timely basis, and (IV) delinquency and enforcement activities), (ii) the collection and distribution of support payments (both intra- and inter-State), the determination, collection, and distribution of incentive payments both inter- and intra-State, and the maintenance of accounts receivable on all amounts owed, collected and distributed, and (iii) the costs of all services rendered, either directly or by interfacing with State financial management and expenditure information, (B) to provide interface with records of the State's aid to families with dependent children program in order to determine if a collection of a support payment causes a change affecting eligibility for or the amount of aid under such program, (C) to provide for security against unauthorized access to, or use of, the data in such system, (D) to facilitate the development and improvement of the income withholding and other procedures

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[154] See Vol. II, 31 U.S.C. 9309, with respect to priority of sureties.

required under section 466(a) through the monitoring of support payments, the maintenance of accurate records regarding the payment of support, and the prompt provision of notice to appropriate officials with respect to any arrearages in support payments which may occur, and (E) to provide management information on all cases under the State plan from initial referral or application through collection and enforcement;

(17) in the case of a State which has in effect an agreement with the Secretary entered into pursuant to section 463 for the use of the Parent Locator Service established under section 453, provide that the State will accept and transmit to the Secretary requests for information authorized under the provisions of the agreement to be furnished by such Service to authorized persons, will impose and collect (in accordance with regulations of the Secretary) a fee sufficient to cover the costs to the State and to the Secretary incurred by reason of such requests, will transmit to the Secretary from time to time (in accordance with such regulations) so much of the fees collected as are attributable to such costs to the Secretary so incurred, and during the period that such agreement is in effect will otherwise comply with such agreement and regulations of the Secretary with respect thereto;

(18) provide that the State has in effect procedures necessary to obtain payment of past-due support from overpayments made to the Secretary of the Treasury as set forth in section 464, and take all steps necessary to implement and utilize such procedures;

(19) provide that the agency administering the plan—

(A) shall determine on a periodic basis, from information supplied pursuant to section 508 of the Unemployment Compensation Amendments of 1976[155], whether any individuals receiving compensation under the State's unemployment compensation law (including amounts payable pursuant to any agreement under any Federal unemployment compensation law) owe child support obligations which are being enforced by such agency, and

(B) shall enforce any such child support obligations which are owed by such an individual but are not being met—

(i) through an agreement with such individual to have specified amounts withheld from compensation otherwise payable to such individual and by submitting a copy of any such agreement to the State agency administering the unemployment compensation law, or

(ii) in the absence of such an agreement, by bringing legal process (as defined in section 462(e) of this Act) to require the withholding of amounts from such compensation;

(20) provide, to the extent required by section 466, that the State (A) shall have in effect all of the laws to improve child support enforcement effectiveness which are referred to in that section, and (B) shall implement the procedures which are prescribed in or pursuant to such laws;

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[155] P.L. 94-566.

(21)(A) at the option of the State, impose a late payment fee on all overdue support (as defined in section 466(e)) under any obligation being enforced under this part, in an amount equal to a uniform percentage determined by the State (not less than 3 percent nor more than 6 percent) of the overdue support, which shall be payable by the absent parent owing the overdue support; and

(B) assure that the fee will be collected in addition to, and only after full payment of, the overdue support, and that the imposition of the late payment fee shall not directly or indirectly result in a decrease in the amount of the support which is paid to the child (or spouse) to whom, or on whose behalf, it is owed;

(22) in order for the State to be eligible to receive any incentive payments under section 458, provide that, if one or more political subdivisions of the State participate in the costs of carrying out activities under the State plan during any period, each such subdivision shall be entitled to receive an appropriate share (as determined by the State) of any such incentive payments made to the State for such period, taking into account the efficiency and effectiveness of the activities carried out under the State plan by such political subdivision;

(23) provide that the State will regularly and frequently publicize, through public service announcements, the availability of child support enforcement services under the plan and otherwise, including information as to any application fees for such services and a telephone number or postal address at which further information may be obtained; and

(24) provide that if the State, as of the date of the enactment of this paragraph[156], does not have in effect an automated data processing and information retrieval system meeting all of the requirements of paragraph (16), the State—

(A) will submit to the Secretary by October 1, 1991, for review and approval by the Secretary within 9 months after submittal an advance automated data processing planning document of the type referred to in such paragraph; and

(B) will have in effect by October 1, 1995, an operational automated data processing and information retrieval system, meeting all the requirements of that paragraph, which has been approved by the Secretary.

The State may allow the jurisdiction which makes the collection involved to retain any application fee under paragraph (6)(B) or any late payment fee under paragraph (21).

PAYMENTS TO STATES[157]

SEC. 455. [42 U.S.C. 655] (a)(1) From the sums appropriated therefor, the Secretary shall pay to each State for each quarter an amount—

(A) equal to the percent specified in paragraph (2) of the total amounts expended by such State during such quarter for the operation of the plan approved under section 454,[158]

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[156] This paragraph was enacted on October 13, 1988 [P.L. 100-485; 102 Stat. 2352].

[157] See Vol. II, P.L. 99-177, Title II, "Balanced Budget and Emergency Deficit Control Act of 1985", §256 [as amended by P.L. 100-119], with respect to treatment of child enforcement program; and §257(11), with respect to references to §401(c)(2) of the "Congressional Budget Act of 1974".

(B) equal to 90 percent (rather than the percent specified in subparagraph (A)) of so much of the sums expended during such quarter as are attributable to the planning, design, development, installation or enhancement of an automatic data processing and information retrieval system (including in such sums the full cost of the hardware components of such system) which the Secretary finds meets the requirements specified in section 454(16), or meets such requirements without regard to clause (D) thereof, and[159]

(C)[160] equal to 90 percent (rather than the percentage specified in subparagraph (A))[161] of so much of the sums expended during such quarter as are attributable to laboratory costs incurred in determining paternity;[162]

except that no amount shall be paid to any State on account of amounts expended to carry out an agreement which it has entered into pursuant to section 463. In determining the total amounts expended by any State during a quarter, for purposes of this subsection, there shall be excluded an amount equal to the total of any fees collected or other income resulting from services provided under the plan approved under this part.

(2) The percent applicable to quarters in a fiscal year for purposes of paragraph (1)(A) is—

(A) 70 percent for fiscal years 1984, 1985, 1986, and 1987,

(B) 68 percent for fiscal years 1988 and 1989, and

(C) 66 percent for fiscal year 1990 and each fiscal year thereafter.

(b)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) Subject to subsection (d), the Secretary shall then pay, in such installments as he may determine, to the State the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

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[158] P.L. 100-485, §112(a)(1), struck out "and". P.L. 100-485, §123(c)(1), provides that this subparagraph shall be stricken, effective September 30, 1995.

[159] P.L. 100-485, §112(a)(2), struck out the semicolon and substituted ", and". P.L. 100-485, §123(c)(1), provides that this subparagraph shall be stricken effective September 30, 1995.

[160] P.L. 100-485, §123(c)(2), provides that this subparagraph shall be redesignated subparagraph (A), effective September 30, 1995.

[161] P.L. 100-485, §123(c)(3)(A), provides that "(rather than the percentage specified in subparagraph (A))" shall be stricken, effective September 30, 1995

[162] P.L. 100-485, §123(c)(3)(B), provides that "and" shall be inserted after the semicolon, effective September 30, 1995.

P.L. 100-485, §123(c)(4), provides that the following subparagraph shall be inserted, effective September 30, 1995:

> "(B) equal to the percent specified in paragraph (2) of the total amounts expended by such State during such quarter for the operation of the plan approved under section 454;".

(3) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

[(c) Repealed.[163]]

(d) Notwithstanding any other provision of law, no amount shall be paid to any State under this section for any quarter, prior to the close of such quarter, unless for the period consisting of all prior quarters for which payment is authorized to be made to such State under subsection (a), there shall have been submitted by the State to the Secretary, with respect to each quarter in such period (other than the last two quarters in such period), a full and complete report (in such form and manner and containing such information as the Secretary shall prescribe or require) as to the amount of child support collected and disbursed and all expenditures with respect to which payment is authorized under subsection (a).

(e)(1) In order to encourage and promote the development and use of more effective methods of enforcing support obligations under this part in cases where either the children on whose behalf the support is sought or their absent parents do not reside in the State where such cases are filed, the Secretary is authorized to make grants, in such amounts and on such terms and conditions as the Secretary determines to be appropriate, to States which propose to undertake new or innovative methods of support collection in such cases and which will use the proceeds of such grants to carry out special projects designed to demonstrate and test such methods.

(2) A grant under this subsection shall be made only upon a finding by the Secretary that the project involved is likely to be of significant assistance in carrying out the purpose of this subsection; and with respect to such project the Secretary may waive any of the requirements of this part which would otherwise be applicable, to such extent and for such period as the Secretary determines is necessary or desirable in order to enable the State to carry out the project.

(3) At the time of its application for a grant under this subsection the State shall submit to the Secretary a statement describing in reasonable detail the project for which the proceeds of the grant are to be used, and the State shall from time to time thereafter submit to the Secretary such reports with respect to the project as the Secretary may specify.

(4) Amounts expended by a State in carrying out a special project assisted under this section shall be considered, for purposes of section 458(b) (as amended by section 5(a) of the Child Support Enforcement Amendments of 1984[164]), to have been expended for the operation of the State's plan approved under section 454.

(5) There is authorized to be appropriated the sum of $7,000,000 for fiscal year 1985, $12,000,000 for fiscal year 1986, and $15,000,000 for each fiscal year thereafter, to be used by the Secretary in making grants under this subsection.

SUPPORT OBLIGATIONS

Sec. 456. [42 U.S.C. 656] (a)(1) The support rights assigned to the State under section 402(a)(26) or secured on behalf of a child receiving foster care maintenance payments shall constitute an obligation owed to such State by the individual responsible for providing such support. Such obligation shall be deemed for collection purposes to be collectible under all applicable State and local processes.

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[163] P.L. 97-248, §174(b); 96 Stat. 403.
[164] P.L. 98-378.

(2) The amount of such obligation shall be—

(A) the amount specified in a court order which covers the assigned support rights, or

(B) if there is no court order, an amount determined by the State in accordance with a formula approved by the Secretary, and

(3) Any amounts collected from an absent parent under the plan shall reduce, dollar for dollar, the amount of his obligation under subparagraphs (A) and (B) of paragraph (2).

(b) A debt which is a child support obligation assigned to a State under section 402(a)(26) is not released by a discharge in bankruptcy under title 11, United States Code.

DISTRIBUTION OF PROCEEDS

SEC. 457. [42 U.S.C. 657] (a) The amounts collected as child support by a State pursuant to a plan approved under this part during the 15 months beginning July 1, 1975, shall be distributed as follows:

(1) 40 per centum of the first $50 of such amounts as are collected periodically which represent monthly support payments shall be paid to the family without any decrease in the amount paid as assistance to such family during such month;

(2) such amounts as are collected periodically which are in excess of any amount paid to the family under paragraph (1) which represent monthly support payments shall be retained by the State to reimburse it for assistance payments to the family during such period (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing);

(3) such amounts as are in excess of amounts retained by the State under paragraph (2) and are not in excess of the amount required to be paid during such period to the family by a court order shall be paid to the family; and

(4) such amounts as are in excess of amounts required to be distributed under paragraphs (1), (2), and (3) shall be (A) retained by the State (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing) as reimbursement for any past assistance payments made to the family for which the State has not been reimbursed or (B) if no assistance payments have been made by the State which have not been repaid, such amounts shall be paid to the family.

(b) The amounts collected as support by a State pursuant to a plan approved under this part during any fiscal year beginning after September 30, 1976, shall (subject to subsection (d)) be distributed as follows:

(1) of such amounts as are collected periodically which represent monthly support payments, the first $50 of any payments for a month received in that month, and the first $50 of payments for each prior month received in that month which

were made by the absent parent in the month when due, shall be paid to the family without affecting its eligibility for assistance or decreasing any amount otherwise payable as assistance to such family during such month;

(2) such amounts as are collected periodically which are in excess of any amount paid to the family under paragraph (1) and which represent monthly support payments shall be retained by the State to reimburse it for assistance payments to the family during such period (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing);

(3) such amounts as are in excess of amounts retained by the State under paragraph (2) and are not in excess of the amount required to be paid during such period to the family by a court or administrative order shall be paid to the family; and

(4) such amounts as are in excess of amounts required to be distributed under paragraphs (1), (2), and (3) shall be (A) retained by the State (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing) as reimbursement for any past assistance payments made to the family for which the State has not been reimbursed or (B) if no assistance payments have been made by the State which have not been repaid, such amounts shall be paid to the family.

(c) Whenever a family with respect to which child support enforcement services have been provided pursuant to section 454(4) ceases to receive assistance under part A of this title, the State shall provide appropriate notice to the family and continue to provide such services, and pay any amount of support collected, subject to the same conditions and on the same basis as in the case of the individuals to whom services are furnished pursuant to section 454(6), except that no application or other request to continue services shall be required of a family to which this subsection applies, and the provisions of section 454(6)(B) may not be applied.

(d) Notwithstanding the preceding provisions of this section, amounts collected by a State as child support for months in any period on behalf of a child for whom a public agency is making foster care maintenance payments under part E—

(1) shall be retained by the State to the extent necessary to reimburse it for the foster care maintenance payments made with respect to the child during such period (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing);

(2) shall be paid to the public agency responsible for supervising the placement of the child to the extent that the amounts collected exceed the foster care maintenance payments made with respect to the child during such period but not the amounts required by a court or administrative order to be paid as support on behalf of the child during such period; and the responsible agency may use the payments in the manner it determines will serve the best interests of the child, including setting such payments aside for the child's future needs or making all or a part thereof available to the person responsible for meeting the child's day-to-day needs; and

(3) shall be retained by the State, if any portion of the amounts collected remains after making the payments required under paragraphs (1) and (2), to the extent that such portion is necessary to reimburse the State (with appropriate reimbursement to the Federal Government to the extent of its participation in the financing) for any past foster care maintenance payments (or payments of aid to families with dependent children) which were made with respect to the child (and with respect to which past collections have not previously been retained);

and any balance shall be paid to the State agency responsible for supervising the placement of the child, for use by such agency in accordance with paragraph (2).

INCENTIVE PAYMENTS TO STATES[165]

SEC. 458. [42 U.S.C. 658] (a) In order to encourage and reward State child support enforcement programs which perform in a cost-effective and efficient manner to secure support for all children who have sought assistance in securing support, whether such children reside within the State or elsewhere and whether or not they are eligible for aid to families with dependent children under a State plan approved under part A of this title, and regardless of the economic circumstances of their parents, the Secretary shall, from support collected which would otherwise represent the Federal share of assistance to families of absent parents, pay to each State for each fiscal year, on a quarterly basis (as described in subsection (e)) beginning with the quarter commencing October 1, 1985, an incentive payment in an amount determined under subsection (b).

(b)(1) Except as provided in paragraphs (2), (3), and (4), the incentive payment shall be equal to—

(A) 6 percent of the total amount of support collected under the plan during the fiscal year in cases in which the support obligation involved is assigned to the State pursuant to section 402(a)(26) or section 471(a)(17) (with such total amount for any fiscal year being hereafter referred to in this section as the State's "AFDC collections" for that year), plus

(B) 6 percent of the total amount of support collected during the fiscal year in all other cases under this part (with such total amount for any fiscal year being hereafter referred to in this section as the State's "non-AFDC collections" for that year).

(2) If subsection (c) applies with respect to a State's AFDC collections or non-AFDC collections for any fiscal year, the percent specified in paragraph (1)(A) or (B) (with respect to such collections) shall be increased to the higher percent determined under such subsection (with respect to such collections) in determining the State's incentive payment under this subsection for that year.

(3) The dollar amount of the portion of the State's incentive payment for any fiscal year which is determined on the basis of its non-AFDC collections under paragraph (1)(B) (after adjustment under subsection (c) if applicable) shall in no case exceed—

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[165] See Vol. II, P.L. 99-177, §256 [as amended by P.L. 100-119], with respect to treatment of child enforcement program; and §257(11), with respect to references to §401(c)(2) of the "Congressional Budget Act of 1974".

(A) the dollar amount of the portion of such payment which is determined on the basis of its AFDC collections under paragraph (1)(A) (after adjustment under subsection (c) if applicable) in the case of fiscal year 1986 or 1987;

(B) 105 percent of such dollar amount in the case of fiscal year 1988;

(C) 110 percent of such dollar amount in the case of fiscal year 1989; or

(D) 115 percent of such dollar amount in the case of fiscal year 1990 or any fiscal year thereafter.

(4) The Secretary shall make such additional payments to the State under this part, for fiscal year 1986 or 1987, as may be necessary to assure that the total amount of payments under this section and section 455(a)(1)(A) for such fiscal year is no less than 80 percent of the amount that would have been payable to that State and its political subdivisions for such fiscal year under this section and section 455(a)(1)(A) if those sections (including the amendment made by section 5(c)(2)(A) of the Child Support Enforcement Amendments of 1984[166]) had remained in effect as they were in effect for fiscal year 1985.

(c) If the total amount of a State's AFDC collections or non-AFDC collections for any fiscal year bears a ratio to the total amount expended by the State in that year for the operation of its plan approved under section 454 for which payment may be made under section 455 (with the total amount so expended in any fiscal year being hereafter referred to in this section as the State's "combined AFDC/non-AFDC administrative costs" for that year) which is equal to or greater than 1.4, the relevant percent specified in subparagraph (A) or (B) of subsection (b)(1) (with respect to such collections) shall be increased to—

(1) 6.5 percent, plus

(2) one-half of 1 percent for each full two-tenths by which such ratio exceeds 1.4;

except that the percent so specified shall in no event be increased (for either AFDC collections or non-AFDC collections) to more than 10 percent. For purposes of the preceding sentence, laboratory costs incurred in determining paternity in any fiscal year may at the option of the State be excluded from the State's combined AFDC/non-AFDC administrative costs for that year.

(d) In computing incentive payments under this section, support which is collected by one State at the request of another State shall be treated as having been collected in full by each such State, and any amounts expended by the State in carrying out a special project assisted under section 455(e) shall be excluded

(e) The amounts of the incentive payments to be made to the various States under this section for any fiscal year shall be estimated by the Secretary at or before the beginning of such year on the basis of the best information available. The Secretary shall make such payments for such year, on a quarterly basis (with each quarterly payment being made no later than the beginning of the quarter involved), in the amounts so estimated, reduced or increased to the extent of any overpayments or underpayments which the

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[166] P.L. 98-378.

Secretary determines were made under this section to the States involved for prior periods and with respect to which adjustment has not already been made under this subsection. Upon the making of any estimate by the Secretary under the preceding sentence, any appropriations available for payments under this section shall be deemed obligated.

CONSENT BY THE UNITED STATES TO GARNISHMENT AND SIMILAR PROCEEDINGS FOR ENFORCEMENT OF CHILD SUPPORT AND ALIMONY OBLIGATIONS

Sec. 459. [42 U.S.C. 659] (a) Notwithstanding any other provision of law (including section 207), effective January 1, 1975, moneys (the entitlement to which is based upon remuneration for employment) due from, or payable by, the United States or the District of Columbia (including any agency, subdivision, or instrumentality thereof) to any individual, including members of the armed services, shall be subject, in like manner and to the same extent as if the United States or the District of Columbia were a private person, to legal process brought for the enforcement, against such individual of his legal obligations to provide child support or make alimony payments.

(b) Service of legal process brought for the enforcement of an individual's obligation to provide child support or make alimony payments shall be accomplished by certified or registered mail, return receipt requested, or by personal service, upon the appropriate agent designated for receipt of such service of process pursuant to regulations promulgated pursuant to section 461 (or, if no agent has been designated for the governmental entity having payment responsibility for the moneys involved, then upon the head of such governmental entity). Such process shall be accompanied by sufficient data to permit prompt identification of the individual and the moneys involved.

(c) No Federal employee whose duties include responding to interrogatories pursuant to requirements imposed by section 461(b)(3) shall be subject under any law to any disciplinary action or civil or criminal liability or penalty for, or on account of, any disclosure of information made by him in connection with the carrying out of any of his duties which pertain (directly or indirectly) to the answering of any such interrogatory.

(d) Whenever any person, who is designated by law or regulation to accept service of process to which the United States is subject under this section, is effectively served with any such process or with interrogatories relating to an individual's child support or alimony payment obligations, such person shall respond thereto within thirty days (or within such longer period as may be prescribed by applicable State law) after the date effective service thereof is made, and shall, as soon as possible but not later than fifteen days after the date effective service is so made of any such process, send written notice that such process has been so served (together with a copy thereof) to the individual whose moneys are affected thereby at his duty station or last-known home address.

(e) Governmental entities affected by legal processes served for the enforcement of an individual's child support or alimony payment obligations shall not be required to vary their normal pay and disbursement cycles in order to comply with any such legal process.

(f) Neither the United States, any disbursing officer, nor governmental entity shall be liable with respect to any payment made from moneys due or payable from the United States to any individual pursuant to legal process regular on its face, if such payment is made in accordance with this section and the regulations issued to carry out this section.

CIVIL ACTIONS TO ENFORCE SUPPORT OBLIGATIONS

SEC. 460. [42 U.S.C. 660] The district courts of the United States shall have jurisdiction, without regard to any amount in controversy, to hear and determine any civil action certified by the Secretary of Health and Human Services under section 452(a)(8) of this Act. A civil action under this section may be brought in any judicial district in which the claim arose, the plaintiff resides, or the defendant resides.

REGULATIONS PERTAINING TO GARNISHMENTS

SEC. 461. [42 U.S.C. 661] (a) Authority to promulgate regulations for the implementation of the provisions of section 459 shall, insofar as the provisions of such section are applicable to moneys due from (or payable by)—

(1) the executive branch of the Government (including in such branch, for the purposes of this subsection, the territories and possessions of the United States, the United States Postal Service, the Postal Rate Commission, any wholly owned Federal corporation created by an Act of Congress, and the government of the District of Columbia), be vested in the President (or his designee),

(2) the legislative branch of the Government, be vested jointly in the President pro tempore of the Senate and the Speaker of the House of Representatives (or their designees), and

(3) the judicial branch of the Government, be vested in the Chief Justice of the United States (or his designee).

(b) Regulations promulgated pursuant to this section shall—

(1) in the case of those promulgated by the executive branch of the Government, include a requirement that the head of each agency thereof shall cause to be published, in the appendix of the regulations so promulgated, (A) his designation of an agent or agents to accept service of process, identified by title of position, mailing address, and telephone number, and (B) an indication of the data reasonably required in order for the agency promptly to identify the individual with respect to whose moneys the legal process is brought,

(2) in the case of regulations promulgated for the legislative and judicial branches of the Government set forth, in the appendix to the regulations so promulgated, (A) the name, position, address, and telephone number of the agent or agents who have been designated for service of process, and (B) an indication of the data reasonably required in order for such entity promptly to identify the individual with respect to whose moneys the legal process is brought, and

(3) provide that (A) in the case of regulations promulgated by the executive branch of the Government, each head of a

governmental entity (or his designee) shall respond to relevant interrogatories, if authorized by the law of the State in which legal process will issue, prior to formal issuance of such process, upon a showing of the applicant's entitlement to child support or alimony payments, and (B) in the case of regulations promulgated for the legislative and judicial branches of the Government, the person or persons designated as agents for service of process in accordance with paragraph (2) shall respond to relevant interrogatories if authorized by the law of the State in which legal process will issue, prior to formal issuance of legal process, upon a showing of the applicant's entitlement to child support or alimony payments.

(c) In the event that a governmental entity, which is authorized under this section or regulations issued to carry out this section to accept service of process, pursuant to the provisions of subsection (a), is served with more than one legal process with respect to the same moneys due or payable to any individual, then such moneys shall be available to satisfy such processes on a first-come, first-served basis, with any such process being satisfied out of such moneys as remain after the satisfaction of all such processes which have been previously served.

DEFINITIONS

SEC. 462. [42 U.S.C. 662] For purposes of section 459—

(a) The term "United States" means the Federal Government of the United States, consisting of the legislative branch, the judicial branch, and the executive branch thereof, and each and every department, agency, or instrumentality of any such branch, including the United States Postal Service, the Postal Rate Commission, any wholly owned Federal corporation created by an Act of Congress, any office, commission, bureau, or other administrative subdivision or creature thereof, and the governments of the territories and possessions of the United States.

(b) The term "child support", when used in reference to the legal obligations of an individual to provide such support, means periodic payments of funds for the support and maintenance of a child or children with respect to which such individual has such an obligation, and (subject to and in accordance with State law) includes but is not limited to, payments to provide for health care, education, recreation, clothing, or to meet other specific needs of such a child or children; such term also includes attorney's fees, interest, and court costs, when and to the extent that the same are expressly made recoverable as such pursuant to a decree, order, or judgment issued in accordance with applicable State law by a court of competent jurisdiction.

(c) The term "alimony", when used in reference to the legal obligations of an individual to provide the same, means periodic payments of funds for the support and maintenance of the spouse (or former spouse) of such individual, and (subject to and in accordance with State law) includes but is not limited to, separate maintenance, alimony pendente lite, maintenance, and spousal support; such term also includes attorney's fees, interest, and court costs when and to the extent that the same are expressly made recoverable as such pursuant to a decree, order, or judgment issued in accordance with applicable State law by a court of competent jurisdiction. Such term does not include any payment or transfer of property or its value by an individual to his spouse or former spouse in compliance with any community property settlement, equitable distribution of property, or other division of property between spouses or former spouses.

(d) The term "private person" means a person who does not have sovereign or other special immunity or privilege which causes such person not to be subject to legal process.

(e) The term "legal process" means any writ, order, summons, or other similar process in the nature of garnishment, which—

(1) is issued by (A) a court of competent jurisdiction within any State, territory, or possession of the United States, (B) a court of competent jurisdiction in any foreign country with which the United States has entered into an agreement which requires the United States to honor such process, or (C) an authorized official pursuant to an order of such a court of competent jurisdiction or pursuant to State or local law, and

(2) is directed to, and the purpose of which is to compel, a governmental entity, which holds moneys which are otherwise payable to an individual, to make a payment from such moneys to another party in order to satisfy a legal obligation of such individual to provide child support or make alimony payments.

(f) Entitlement of an individual to any money shall be deemed to be "based upon remuneration for employment", if such money consists of—

(1) compensation paid or payable for personal services of such individual, whether such compensation is denominated as wages, salary, commission, bonus, pay, or otherwise, and includes but is not limited to, severance pay, sick pay, and incentive pay, but does not include awards for making suggestions, or

(2) periodic benefits (including a periodic benefit as defined in section 228(h)(3) of this Act) or other payments to such individual under the insurance system established by title II of this Act or any other system or fund established by the United States (as defined in subsection (a)) which provides for the payment of pensions, retirement or retired pay, annuities, dependents' or survivors' benefits, or similar amounts payable on account of personal services performed by himself or any other individual (not including any payment as compensation for death under any Federal program, any payment under any Federal program established to provide "black lung" benefits, any payment by the Veterans' Administration as pension, or any payments by the Veterans' Administration as compensation for a service-connected disability or death, except any compensation paid by the Veterans' Administration to a former member of the Armed Forces who is in receipt of retired or retainer pay if such former member has waived a portion of his retired pay in order to receive such compensation), and does not consist of amounts paid, by way of reimbursement or otherwise, to such individual by his employer to defray expenses incurred by such individual in carrying out duties associated with his employment.

(g) In determining the amount of any moneys due from, or payable by, the United States to any individual, there shall be excluded amounts which—

(1) are owed by such individual to the United States,

(2) are required by law to be, and are, deducted from the remuneration or other payment involved, including but not limited to, Federal employment taxes, and fines and forfeitures ordered by court-martial,

(3) are properly withheld for Federal, State, or local income tax purposes, if the withholding of such amounts is authorized or required by law and if amounts withheld are not greater than would be the case if such individual claimed all dependents to which he was entitled (the withholding of additional amounts pursuant to section 3402(i) of the Internal Revenue Code of 1954[167] may be permitted only when such individual presents evidence of a tax obligation which supports the additional withholding),

(4) are deducted as health insurance premiums,

(5) are deducted as normal retirement contributions (not including amounts deducted for supplementary coverage), or

(6) are deducted as normal life insurance premiums from salary or other remuneration for employment (not including amounts deducted for supplementary coverage).

USE OF FEDERAL PARENT LOCATOR SERVICE IN CONNECTION WITH THE ENFORCEMENT OR DETERMINATION OF CHILD CUSTODY AND IN CASES OF PARENTAL KIDNAPING OF A CHILD

SEC. 463. [42 U.S.C. 663] (a) The Secretary shall enter into an agreement with any State which is able and willing to do so, under which the services of the Parent Locator Service established under section 453 shall be made available to such State for the purpose of determining the whereabouts of any absent parent or child when such information is to be used to locate such parent or child for the purpose of—

(1) enforcing any State or Federal law with respect to the unlawful taking or restraint of a child; or

(2) making or enforcing a child custody determination.

(b) An agreement entered into under subsection (a) shall provide that the State agency described in section 454 will, under procedures prescribed by the Secretary in regulations, receive and transmit to the Secretary requests from authorized persons for information as to (or useful in determining) the whereabouts of any absent parent or child when such information is to be used to locate such parent or child for the purpose of—

(1) enforcing any State or Federal law with respect to the unlawful taking or restraint of a child; or

(2) making or enforcing a child custody determination.

(c) Information authorized to be provided by the Secretary under subsection (a), (b), or (e) shall be subject to the same conditions with respect to disclosure as information authorized to be provided under section 453, and a request for information by the Secretary under this section shall be considered to be a request for information under section 453 which is authorized to be provided under such section. Only information as to the most recent address and place of employment of any absent parent or child shall be provided under this section.

(d) For purposes of this section—

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[167] See P.L. 83-591, §3402(i), (this volume).

(1) the term "custody determination" means a judgment, decree, or other order of a court providing for the custody or visitation of a child, and includes permanent and temporary orders, and initial orders and modification;

(2) the term "authorized person" means—

(A) any agent or attorney of any State having an agreement under this section, who has the duty or authority under the law of such State to enforce a child custody determination;

(B) any court having jurisdiction to make or enforce such a child custody determination, or any agent of such court; and

(C) any agent or attorney of the United States, or of a State having an agreement under this section, who has the duty or authority to investigate, enforce, or bring a prosecution with respect to the unlawful taking or restraint of a child.

(e) The Secretary shall enter into an agreement with the Central Authority designated by the President in accordance with section 7 of the International Child Abduction Remedies Act[168], under which the services of the Parent Locator Service established under section 453 shall be made available to such Central Authority upon its request for the purpose of locating any parent or child on behalf of an applicant to such Central Authority within the meaning of section 3(1) of that Act. The Parent Locator Service shall charge no fees for services requested pursuant to this subsection.

COLLECTION OF PAST-DUE SUPPORT FROM FEDERAL TAX REFUNDS

SEC. 464. [42 U.S.C. 664] (a)(1) Upon receiving notice from a State agency administering a plan approved under this part that a named individual owes past-due support which has been assigned to such State pursuant to section 402(a)(26) or section 471(a)(17), the Secretary of the Treasury shall determine whether any amounts, as refunds of Federal taxes paid, are payable to such individual (regardless of whether such individual filed a tax return as a married or unmarried individual). If the Secretary of the Treasury finds that any such amount is payable, he shall withhold from such refunds an amount equal to the past-due support, shall concurrently send notice to such individual that the withholding has been made (including in or with such notice a notification to any other person who may have filed a joint return with such individual of the steps which such other person may take in order to secure his or her proper share of the refund), and shall pay such amount to the State agency (together with notice of the individual's home address) for distribution in accordance with section 457(b)(4) or (d)(3).

(2)(A) Upon receiving notice from a State agency administering a plan approved under this part that a named individual owes past-due support (as that term is defined for purposes of this paragraph under subsection (c)) which such State has agreed to collect under section 454(6), and that the State agency has sent notice to such individual in accordance with paragraph (3)(A), the Secretary of the Treasury shall determine whether any amounts, as refunds of Federal taxes paid, are payable to such individual (regardless of whether such individual filed a tax return as a married or unmarried individual). If the Secretary of the Treasury finds that any such amount is payable, he shall withhold from such refunds an amount equal to such past-due support, and shall concurrently send notice to such individual that the withholding has been made, including in or with such notice a notification to any other person who may have filed a joint return with such individual of the steps which such other person may take in order to secure his or her proper share of the refund. The Secretary of the Treasury shall pay the amount withheld to the State agency, and the State shall pay to the Secretary of the Treasury any fee imposed by the Secretary of the Treasury to cover the costs of the withholding and any required notification. The State agency shall, subject to paragraph (3)(B), distribute such amount to or on behalf of the child to whom the support was owed.

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[168] P.L. 100-300.

(B) This paragraph shall apply only with respect to refunds payable under section 6402 of the Internal Revenue Code of 1954[169] after December 31, 1985[170]. [171]

(3)(A) Prior to notifying the Secretary of the Treasury under paragraph (1) or (2) that an individual owes past-due support, the State shall send notice to such individual that a withholding will be made from any refund otherwise payable to such individual. The notice shall also (i) instruct the individual owing the past-due support of the steps which may be taken to contest the State's determination that past-due support is owed or the amount of the past-due support, and (ii) provide information, as may be prescribed by the Secretary of Health and Human Services by regulation in consultation with the Secretary of the Treasury, with respect to procedures to be followed, in the case of a joint return, to protect the share of the refund which may be payable to another person.

(B) If the Secretary of the Treasury determines that an amount should be withheld under paragraph (1) or (2), and that the refund from which it should be withheld is based upon a joint return, the Secretary of the Treasury shall notify the State that the withholding is being made from a refund based upon a joint return, and shall furnish to the State the names and addresses of each taxpayer filing such joint return. In the case of a withholding under paragraph (2), the State may delay distribution of the amount withheld until the State has been notified by the Secretary of the Treasury that the other person filing the joint return has received his or her proper share of the refund, but such delay may not exceed six months.

(C) If the other person filing the joint return with the named individual owing the past-due support takes appropriate action to secure his or her proper share of a refund from which a withholding was made under paragraph (1) or (2), the Secretary of the Treasury shall pay such share to such other person. The Secretary of the Treasury shall deduct the amount of such payment from amounts subsequently payable to the State agency to which the amount originally withheld from such refund was paid.

(D) In any case in which an amount was withheld under paragraph (1) or (2) and paid to a State, and the State subsequently determines that the amount certified as past-due support was in excess of the amount actually owed at the time the amount withheld is to be distributed to or on behalf of the child, the State shall pay the excess amount withheld to the named individual thought to have owed the past-due support (or, in the case of amounts withheld on the basis of a joint return, jointly to the parties filing such return).

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[169] P.L. 83-591.

[170] P.L. 101-508, §5011(a), struck out ", and before January 1, 1991", effective November 5, 1990.

[171] See Vol. II, P.L. 100-203, §9402(b), with respect to the Congressional intent as to the scope of P.L. 83-591, §6402(d)-(g) (added by P.L. 98-369).

(b)(1) The Secretary of the Treasury shall issue regulations, approved by the Secretary of Health and Human Services, prescribing the time or times at which States must submit notices of past-due support, the manner in which such notices must be submitted, and the necessary information that must be contained in or accompany the notices. The regulations shall be consistent with the provisions of subsection (a)(3), shall specify the minimum amount of past-due support to which the offset procedure established by subsection (a) may be applied, and the fee that a State must pay to reimburse the Secretary of the Treasury for the full cost of applying the offset procedure, and shall provide that the Secretary of the Treasury will advise the Secretary of Health and Human Services, not less frequently than annually, of the States which have furnished notices of past-due support under subsection (a), the number of cases in each State with respect to which such notices have been furnished, the amount of support sought to be collected under this subsection by each State, and the amount of such collections actually made in the case of each State. Any fee paid to the Secretary of the Treasury pursuant to this subsection may be used to reimburse appropriations which bore all or part of the cost of applying such procedure.

(2) In the case of withholdings made under subsection (a)(2), the regulations promulgated pursuant to this subsection shall include the following requirements:

(A) The withholding shall apply only in the case where the State determines that the amount of the past-due support which will be owed at the time the withholding is to be made, based upon the pattern of payment of support and other enforcement actions being pursued to collect the past-due support, is equal to or greater than $500. The State may limit the $500 threshold amount to amounts of past-due support accrued since the time that the State first began to enforce the child support order involved under the State plan, and may limit the application of the withholding to past-due support accrued since such time.

(B) The fee which the Secretary of the Treasury may impose to cover the costs of the withholding and notification may not exceed $25 per case submitted.

(c)(1) Except as provided in paragraph (2), as used in this part the term "past-due support" means the amount of a delinquency, determined under a court order, or an order of an administrative process established under State law, for support and maintenance of a child, or of a child and the parent with whom the child is living.

(2) For purposes of subsection (a)(2), the term "past-due support" means only past-due support owed to or on behalf of a qualified child (or a qualified child and the parent with whom the child is living if the same support order includes support for the child and the parent).[172]

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[172] P.L. 101-508, §5011(b)(1), struck out "minor child." and substituted "qualified child (or a qualified child and the parent with whom the child is living if the same support order includes support for the child and the parent).", effective January 1, 1991.

(3) For purposes of paragraph (2), the term "qualified child" means a child—

(A) who is a minor; or

(B)(i) who, while a minor, was determined to be disabled under title II or XVI; and

(ii) for whom an order of support is in force.[173]

ALLOTMENTS FROM PAY FOR CHILD AND SPOUSAL SUPPORT OWED BY MEMBERS OF THE UNIFORMED SERVICES ON ACTIVE DUTY

SEC. 465. [42 U.S.C. 665] (a)(1) In any case in which child support payments or child and spousal support payments are owed by a member of one of the uniformed services (as defined in section 101(3) of title 37, United States Code) on active duty, such member shall be required to make allotments from his pay and allowances (under chapter 13 of title 37, United States Code) as payment of such support, when he has failed to make periodic payments under a support order that meets the criteria specified in section 303(b)(1)(A) of the Consumer Credit Protection Act[174] (15 U.S.C. 1673(b)(1)(A)) and the resulting delinquency in such payments is in a total amount equal to the support payable for two months or longer. Failure to make such payments shall be established by notice from an authorized person (as defined in subsection (b)) to the designated official in the appropriate uniformed service. Such notice (which shall in turn be given to the affected member) shall also specify the person to whom the allotment is to be payable. The amount of the allotment shall be the amount necessary to comply with the order (which, if the order so provides, may include arrearages as well as amounts for current support), except that the amount of the allotment, together with any other amounts withheld for support from the wages of the member, as a percentage of his pay from the uniformed service, shall not exceed the limits prescribed in sections 303(b) and (c) of the Consumer Credit Protection Act[175] (15 U.S.C. 1673(b) and (c)). An allotment under this subsection shall be adjusted or discontinued upon notice from the authorized person.

(2) Notwithstanding the preceding provisions of this subsection, no action shall be taken to require an allotment from the pay and allowances of any member of one of the uniformed services under such provisions (A) until such member has had a consultation with a judge advocate of the service involved (as defined in section 801(13) of title 10, United States Code), or with a law specialist (as defined in section 801(11) of such title) in the case of the Coast Guard, or with a legal officer designated by the Secretary concerned (as defined in section 101(5) of title 37, United States Code) in any other case, in person, to discuss the legal and other factors involved with respect to the member's support obligation and his failure to make payments thereon, or (B) until 30 days have elapsed after the notice described in the second sentence of paragraph (1) is given to the affected member in any case where it has not been possible, despite continuing good faith efforts, to arrange such a consultation.

(b) For purposes of this section the term "authorized person" with respect to any member of the uniformed services means—

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[173] P.L. 101-508, §5011(b)(2), added paragraph (3), effective January 1, 1991.

[174] P.L. 90-321.

[175] P.L. 90-321.

(1) any agent or attorney of a State having in effect a plan approved under this part who has the duty or authority under such plan to seek to recover any amounts owed by such member as child or child and spousal support (including, when authorized under the State plan, any official of a political subdivision); and

(2) the court which has authority to issue an order against such member for the support and maintenance of a child, or any agent of such court.

(c) The Secretary of Defense, in the case of the Army, Navy, Air Force, and Marine Corps, and the Secretary concerned (as defined in section 101(5) of title 37, United States Code) in the case of each of the other uniformed services, shall each issue regulations applicable to allotments to be made under this section, designating the officials to whom notice of failure to make support payments, or notice to discontinue or adjust an allotment, should be given, prescribing the form and content of the notice and specifying any other rules necessary for such Secretary to implement this section.

REQUIREMENT OF STATUTORILY PRESCRIBED PROCEDURES TO IMPROVE EFFECTIVENESS OF CHILD SUPPORT ENFORCEMENT[176]

SEC. 466. [42 U.S.C. 666] (a) In order to satisfy section 454(20)(A), each State must have in effect laws requiring the use of the following procedures, consistent with this section and with regulations of the Secretary, to increase the effectiveness of the program which the State administers under this part:

(1) Procedures described in subsection (b) for the withholding from income of amounts payable as support.

(2) Procedures under which expedited processes (determined in accordance with regulations of the Secretary) are in effect under the State judicial system or under State administrative processes (A) for obtaining and enforcing support orders, and (B) at the option of the State, for establishing paternity. The Secretary may waive the provisions of this paragraph with respect to one or more political subdivisions within the State on the basis of the effectiveness and timeliness of support order issuance and enforcement within the political subdivision (in accordance with the general rule for exemptions under subsection (d)).

(3) Procedures under which the State child support enforcement agency shall request, and the State shall provide, that for the purpose of enforcing a support order under any State plan approved under this part—

(A) any refund of State income tax which would otherwise be payable to an absent parent will be reduced, after notice has been sent to that absent parent of the proposed reduction and the procedures to be followed to contest it (and after full compliance with all procedural due process requirements of the State), by the amount of any overdue support owed by such absent parent;

(B) the amount by which such refund is reduced shall be distributed in accordance with section 457(b)(4) or (d)(3) in the case of overdue support assigned to a State pursuant to section 402(a)(26) or 471(a)(17), or, in the case of overdue support which a State has agreed to collect under section 454(6), shall be distributed, after deduction of any fees imposed by the State to cover the costs of collection, to the child or parent to whom such support is owed; and

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[176] See Vol. II, P.L. 100-485, §101(c), with respect to a study on making immediate income withholding mandatory in all cases; §103(d), with respect to a study of impact of extending a periodic review requirement to all other cases; and §103(e), with respect to demonstration projects for evaluating model procedures for reviewing child support awards.

(C) notice of the absent parent's social security account number (or numbers, if he has more than one such number) and home address shall be furnished to the State agency requesting the refund offset, and to the State agency enforcing the order.

(4) Procedures under which liens are imposed against real and personal property for amounts of overdue support owed by an absent parent who resides or owns property in the State.

(5)(A)(i) Procedures which permit the establishment of the paternity of any child at any time prior to such child's eighteenth birthday.

(ii) As of August 16, 1984, the requirement of clause (i) shall also apply to any child for whom paternity has not yet been established and any child for whom a paternity action was brought but dismissed because a statute of limitations of less than 18 years was then in effect in the State.[177]

(B) Procedures under which the State is required (except in cases where the individual involved has been found under section 402(a)(26)(B) to have good cause for refusing to cooperate) to require the child and all other parties, in a contested paternity case, to submit to genetic tests upon the request of any such party.[178]

(6) Procedures which require that an absent parent give security, post a bond, or give some other guarantee to secure payment of overdue support, after notice has been sent to such absent parent of the proposed action and of the procedures to be followed to contest it (and after full compliance with all procedural due process requirements of the State).

(7) Procedures by which information regarding the amount of overdue support owed by an absent parent residing in the State will be made available to any consumer reporting agency (as defined in section 603(f) of the Fair Credit Reporting Act[179] (15 U.S.C. 1681a(f))) upon the request of such agency; except that (A) if the amount of the overdue support involved in any case is less than $1,000, information regarding such amount shall be made available only at the option of the State, (B) any information with respect to an absent parent shall be made available under such procedures only after notice has been sent to such absent parent of the proposed action, and such absent parent has been given a reasonable opportunity to contest the accuracy of such information (and after full compliance with all procedural due process requirements of the State), and (C) a fee for furnishing such information, in an amount not exceeding the actual cost thereof, may be imposed on the requesting agency by the State.

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[177] Alignment as in original.

[178] P.L. 100-485, §111(b)(2), added subparagraph (B), effective November 1, 1989.

[179] P.L. 90-321, Title VI.

(8)(A) Procedures under which all child support orders not described in subparagraph (B)[180] will include provision for withholding from wages, in order to assure that withholding as a means of collecting child support is available if arrearages occur without the necessity of filing application for services under this part.

(B) Procedures under which all child support orders which are initially issued in the State on or after January 1, 1994, and are not being enforced under this part will include the following requirements:

(i) The wages of an absent parent shall be subject to withholding, regardless of whether support payments by such parent are in arrears, on the effective date of the order; except that such wages shall not be subject to withholding under this clause in any case where (I) one of the parties demonstrates, and the court (or administrative process) finds, that there is good cause not to require immediate income withholding, or (II) a written agreement is reached between both parties which provides for an alternative arrangement.

(ii) The requirements of subsection (b)(1) (which shall apply in the case of each absent parent against whom a support order is or has been issued or modified in the State, without regard to whether the order is being enforced under the State plan).

(iii) The requirements of paragraphs (2), (5), (6), (7), (8), (9), and (10) of subsection (b), where applicable.

(iv) Withholding from income of amounts payable as support must be carried out in full compliance with all procedural due process requirements of the State.[181]

(9) Procedures which require that any payment or installment of support under any child support order, whether ordered through the State judicial system or through the expedited processes required by paragraph (2), is (on and after the date it is due)—

(A) a judgment by operation of law, with the full force, effect, and attributes of a judgment of the State, including the ability to be enforced,

(B) entitled as a judgment to full faith and credit in such State and in any other State, and

(C) not subject to retroactive modification by such State or by any other State;

except that such procedures may permit modification with respect to any period during which there is pending a petition for modification, but only from the date that notice of such petition has been given, either directly or through the appropriate agent, to the obligee or (where the obligee is the petitioner) to the obligor.

(10)(A) Procedures to ensure that, beginning 2 years after the date of the enactment of this paragraph[182], if the State determines (pursuant to a plan indicating how and when child support orders in effect in the State are to be periodically reviewed and adjusted) that a child support order being enforced under this part should be reviewed, the State must, at the request of either parent subject to the order, or of a State child support enforcement agency, initiate a review of such order, and adjust such order, as appropriate, in accordance with the guidelines established pursuant to section 467(a).

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[180] P.L. 100-485, §101(b)(2), struck out "which are issued or modified in the State" and substituted "not described in subparagraph (B)", effective January 1, 1994.

[181] P.L. 100-485, §101(b)(3), added subparagraph (B), effective January 1, 1994.

[182] This paragraph was enacted on October 13, 1988 [P.L. 100-485; 102 Stat. 2346].

(B) Procedures to ensure that, beginning 5 years after the date of the enactment of this paragraph or such earlier date as the State may select, the State must implement a process for the periodic review and adjustment of child support orders being enforced under this part under which the order is to be reviewed not later than 36 months after the establishment of the order or the most recent review, and adjusted, as appropriate, in accordance with the guidelines established pursuant to section 467(a), unless—

(i) in the case of an order with respect to an individual with respect to whom an assignment under section 402(a)(26) is in effect, the State has determined, in accordance with regulations of the Secretary, that such a review would not be in the best interests of the child and neither parent has requested review; and

(ii) in the case of any other order being enforced under this part, neither parent has requested review.

(C) Procedures to ensure that the State notifies each parent subject to a child support order in effect in the State that is being enforced under this part—

(i) of any review of such order, at least 30 days before the commencement of such review; and

(ii) of the right of such parent under subparagraph (B) to request the State to review such order; and

(iii) of a proposed adjustment (or determination that there should be no change) in the child support award amount, and such parent is afforded not less than 30 days after such notification to initiate proceedings to challenge such adjustment (or determination).[183]

Notwithstanding section 454(20)(B), the procedures which are required under paragraphs (3), (4), (6), and (7) need not be used or applied in cases where the State determines (using guidelines which are generally available within the State and which take into account the payment record of the absent parent, the availability of other remedies, and other relevant considerations) that such use or application would not carry out the purposes of this part or would be otherwise inappropriate in the circumstances.

(b) The procedures referred to in subsection (a)(1) (relating to the withholding from income of amounts payable as support) must provide for the following:

(1) In the case of each absent parent against whom a support order is or has been issued or modified in the State, and is being enforced under the State plan, so much of such parent's wages (as defined by the State for purposes of this section) must be

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[183] P.L. 100-485, §103(c), added paragraph (10), effective October 13, 1989.

withheld, in accordance with the succeeding provisions of this subsection, as is necessary to comply with the order and provide for the payment of any fee to the employer which may be required under paragraph (6)(A), up to the maximum amount permitted under section 303(b) of the Consumer Credit Protection Act[184] (15 U.S.C. 1673(b)). If there are arrearages to be collected, amounts withheld to satisfy such arrearages, when added to the amounts withheld to pay current support and provide for the fee, may not exceed the limit permitted under such section 303(b), but the State need not withhold up to the maximum amount permitted under such section in order to satisfy arrearages.

(2) Such withholding must be provided without the necessity of any application therefor in the case of a child (whether or not eligible for aid under part A) with respect to whom services are already being provided under the State plan under this part, and must be provided in accordance with this subsection on the basis of an application for services under the State plan in the case of any other child in whose behalf a support order has been issued or modified in the State. In either case such withholding must occur without the need for any amendment to the support order involved or for any further action (other than those actions required under this part) by the court or other entity which issued such order.

(3)(A) The wages of an absent parent shall be subject to such withholding, regardless of whether support payments by such parent are in arrears, in the case of a support order being enforced under this part that is issued or modified on or after the first day of the 25th month beginning after the date of the enactment of this paragraph[185], on the effective date of the order; except that such wages shall not be subject to such withholding under this subparagraph in any case where (i) one of the parties demonstrates, and the court (or administrative process) finds, that there is good cause not to require immediate income withholding, or (ii) a written agreement is reached between both parties which provides for an alternative arrangement.

(B) The wages of an absent parent shall become subject to such withholding, in the case of wages not subject to withholding under subparagraph (A), on the date on which the payments which the absent parent has failed to make under a support order are at least equal to the support payable for one month or, if earlier, and without regard to whether there is an arrearage, the earliest of—

(i) the date as of which the absent parent requests that such withholding begin,

(ii) the date as of which the custodial parent requests that such withholding begin, if the State determines, in accordance with such procedures and standards as it may establish, that the request should be approved, or

(iii) such earlier date as the State may select.[186]

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[184] P.L. 90-321.

[185] This paragraph was enacted October 1, 1988 [P.L. 100-485; 102 Stat. 2344].

[186] P.L. 100-485, §101(a), amended paragraph (3) in its entirety, effective November 1, 1990. Until then, paragraph (3) reads as follows:

"(3) An absent parent shall become subject to such withholding, (4)(A) Such withholding must be carried out in full compliance with all procedural due process requirements of the State, and (subject to subparagraph (B)) the State must send advance notice to each absent parent to whom paragraph (1) applies regarding the proposed withholding and the procedures such absent parent should follow if he or she desires to contest such withholding on the grounds that withholding (including the amount to be withheld) is not proper in the case involved because of mistakes of fact. If the absent parent contests such withholding on those grounds, the State shall determine whether such withholding will actually occur, shall (within no more than 45 days after the provision of such advance notice) inform such parent of whether or not withholding will occur and (if so) of the date on which it is to begin, and shall furnish such parent with the information contained in any notice given to the employer under paragraph (6)(A) with respect to such withholding.

(B) The requirement of advance notice set forth in the first sentence of subparagraph (A) shall not apply in the case of any State which has a system of income withholding for child support purposes in effect on the date of the enactment of this section[187] if such system provides on that date, and continues to provide, such procedures as may be necessary to meet the procedural due process requirements of State law.

(5) Such withholding must be administered by a public agency designated by the State, and the amounts withheld must be expeditiously distributed by the State or such agency in accordance with section 457 under procedures (specified by the State) adequate to document payments of support and to track and monitor such payments, except that the State may establish or permit the establishment of alternative procedures for the collection and distribution of such amounts (under the supervision of such public agency) otherwise than through such public agency so long as the entity making such collection and distribution is publicly accountable for its actions taken in carrying out such procedures, and so long as such procedures will assure prompt distribution, provide for the keeping of adequate records to document payments of support, and permit the tracking and monitoring of such payments.

(6)(A)(i) The employer of any absent parent to whom paragraph (1) applies, upon being given notice as described in clause (ii), must be required to withhold from such absent parent's wages the amount specified by such notice (which may include a fee, established by the State, to be paid to the employer unless waived by such employer) and pay such amount (after deducting and retaining any portion thereof which represents the fee so established) to the appropriate agency (or other entity authorized to collect the amounts withheld under the alternative proce-

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and the advance notice required under paragraph (4) shall be given, on the earliest of—

"(A) the date on which the payments which the absent parent has failed to make under such order are at least equal to the support payable for one month,

"(B) the date as of which the absent parent requests that such withholding begin, or

"(C) such earlier date as the State may select.".

[187] This section was enacted on August 16, 1984 [P.L. 98-378; 98 Stat. 1306].

dures described in paragraph (5)) for distribution in accordance with section 457.

(ii) The notice given to the employer shall contain only such information as may be necessary for the employer to comply with the withholding order.

(B) Methods must be established by the State to simplify the withholding process for employers to the greatest extent possible, including permitting any employer to combine all withheld amounts into a single payment to each appropriate agency or entity (with the portion thereof which is attributable to each individual employee being separately designated).

(C) The employer must be held liable to the State for any amount which such employer fails to withhold from wages due an employee following receipt by such employer of proper notice under subparagraph (A), but such employer shall not be required to vary the normal pay and disbursement cycles in order to comply with this paragraph.

(D) Provision must be made for the imposition of a fine against any employer who discharges from employment, refuses to employ, or takes disciplinary action against any absent parent subject to wage withholding required by this subsection because of the existence of such withholding and the obligations or additional obligations which it imposes upon the employer.

(7) Support collection under this subsection must be given priority over any other legal process under State law against the same wages.

(8) The State may take such actions as may be necessary to extend its system of withholding under this subsection so that such system will include withholding from forms of income other than wages, in order to assure that child support owed by absent parents in the State will be collected without regard to the types of such absent parents' income or the nature of their income-producing activities.

(9) The State must extend its withholding system under this subsection so that such system will include withholding from income derived within such State in cases where the applicable support orders were issued in other States, in order to assure that child support owed by absent parents in such State or any other State will be collected without regard to the residence of the child for whom the support is payable or of such child's custodial parent.

(10) Provision must be made for terminating withholding.

(c) Any State may at its option, under its plan approved under section 454, establish procedures under which support payments under this part will be made through the State agency or other entity which administers the State's income withholding system in any case where either the absent parent or the custodial parent requests it, even though no arrearages in child support payments are involved and no income withholding procedures have been instituted; but in any such case an annual fee for handling and processing such payments, in an amount not exceeding the actual costs incurred by the State in connection therewith or $25, whichever is less, shall be imposed on the requesting parent by the State.

(d) If a State demonstrates to the satisfaction of the Secretary, through the presentation to the Secretary of such data pertaining to caseloads, processing times, administrative costs, and average support collections, and such other data or estimates as the Secretary may specify, that the enactment of any law or the use of any procedure or procedures required by or pursuant to this section will not increase the effectiveness and efficiency of the State child support enforcement program, the Secretary may exempt the State, subject to the Secretary's continuing review and to termination of the exemption should circumstances change, from the requirement to enact the law or use the procedure or procedures involved.

(e) For purposes of this section, the term "overdue support" means the amount of a delinquency pursuant to an obligation determined under a court order, or an order of an administrative process established under State law, for support and maintenance of a minor child which is owed to or on behalf of such child, or for support and maintenance of the absent parent's spouse (or former spouse) with whom the child is living if and to the extent that spousal support (with respect to such spouse or former spouse) would be included for purposes of paragraph (4) or (6) of section 454. At the option of the State, overdue support may include amounts which otherwise meet the definition in the first sentence of this subsection but which are owed to or on behalf of a child who is not a minor child. The option to include support owed to children who are not minors shall apply independently to each procedure specified under this section.

STATE GUIDELINES FOR CHILD SUPPORT AWARDS

SEC. 467. **[**42 U.S.C. 667**]** (a) Each State, as a condition for having its State plan approved under this part, must establish guidelines for child support award amounts within the State. The guidelines may be established by law or by judicial or administrative action, and shall be reviewed at least once every 4 years to ensure that their application results in the determination of appropriate child support award amounts[188].

(b)(1)[189] The guidelines established pursuant to subsection (a) shall be made available to all judges and other officials who have the power to determine child support awards within such State.[190]

(2) There shall be a rebuttable presumption, in any judicial or administrative proceeding for the award of child support, that the amount of the award which would result from the application of such guidelines is the correct amount of child support to be awarded. A written finding or specific finding on the record that the application of the guidelines would be unjust or inappropriate in a particular case, as determined under criteria established by the State, shall be sufficient to rebut the presumption in that case.[191]

(c) The Secretary shall furnish technical assistance to the States for establishing the guidelines, and each State shall furnish the Secretary with copies of its guidelines.

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[188] P.L. 100-485, §103(b), inserted ", and shall be reviewed at least once every 4 years to ensure that their application results in the determination of appropriate child support award amounts", effective October 13, 1989.

[189] P.L. 100-485, §103(a)(1), inserted "(1)".

[190] P.L. 100-485, §103(a)(2), struck out ", but need not be binding upon such judges or other officials", effective October 13, 1989.

[191] P.L. 100-485, §103(a)(3), added paragraph (2), effective October 13, 1989.

ENCOURAGEMENT OF STATES TO ADOPT SIMPLE CIVIL PROCESS FOR VOLUNTARILY ACKNOWLEDGING PATERNITY AND A CIVIL PROCEDURE FOR ESTABLISHING PATERNITY IN CONTESTED CASES

SEC. 468. [42 U.S.C. 668] In the administration of the child support enforcement program under this part, each State is encouraged to establish and implement a simple civil process for voluntarily acknowledging paternity and a civil procedure for establishing paternity in contested cases.

COLLECTION AND REPORTING OF CHILD SUPPORT ENFORCEMENT DATA

SEC. 469. [42 U.S.C. 669] (a) The Secretary of Health and Human Services shall collect and maintain, on a fiscal year basis, up-to-date statistics, by State, with respect to each of the services specified in subsection (b) (separately stated in the case of each such service for families receiving aid under plans approved under part A and for families not receiving such aid), on—

(1) the number of cases in the child support enforcement agency caseload under part D which need the service involved; and

(2) the number of such cases in which the service has actually been provided.

(b) The services referred to in subsection (a) are—

(1) paternity determination;

(2) location of an absent parent for the purpose of establishing a child support obligation;

(3) establishment of a child support obligation; and

(4) location of an absent parent for the purpose of enforcing or modifying an established child support obligation.

(c) For purposes of subsection (a)(2), a service has actually been provided when the task described by the service has been accomplished.

PART E—FEDERAL PAYMENTS FOR FOSTER CARE AND ADOPTION ASSISTANCE[192]

PURPOSE: APPROPRIATION[193]

SEC. 470. [42 U.S.C. 670] For the purpose of enabling each State to provide, in appropriate cases, foster care and transitional independent living programs for children who otherwise would be eligible for assistance under the State's plan approved under part A and adoption assistance for children with special needs, there are authorized to be appropriated for each fiscal year (commencing with the fiscal year which begins October 1, 1980) such sums as may be necessary to carry out the provisions of this part. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans under this part.

STATE PLAN FOR FOSTER CARE AND ADOPTION ASSISTANCE

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[192] See Vol. II, P.L. 99-177, §256 , with respect to treatment of foster care and adoption assistance programs.

[193] See Vol. II, P.L. 100-505, §§201 and 301, with respect to a study and report on assistance.

SEC. 471. [42 U.S.C. 671] (a) In order for a State to be eligible for payments under this part, it shall have a plan approved by the Secretary which—

(1) provides for foster care maintenance payments in accordance with section 472 and for adoption assistance in accordance with section 473;

(2) provides that the State agency responsible for administering the program authorized by part B of this title shall administer, or supervise the administration of, the program authorized by this part;

(3) provides that the plan shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(4) provides that the State shall assure that the programs at the local level assisted under this part will be coordinated with the programs at the State or local level assisted under parts A and B of this title, under title XX of this Act, and under any other appropriate provision of Federal law;

(5) provides that the State will, in the administration of its programs under this part, use such methods relating to the establishment and maintenance of personnel standards on a merit basis as are found by the Secretary to be necessary for the proper and efficient operation of the programs, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods;

(6) provides that the State agency referred to in paragraph (2) (hereinafter in this part referred to as the "State agency") will make such reports, in such form and containing such information as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provides that the State agency will monitor and conduct periodic evaluations of activities carried out under this part;

(8) provides safeguards which restrict the use of or disclosure of information concerning individuals assisted under the State plan to purposes directly connected with (A) the administration of the plan of the State approved under this part, the plan or program of the State under part A, B, or D of this title (including activities under part F)[194] or under title I, V, X, XIV, XVI (as in effect in Puerto Rico, Guam, and the Virgin Islands), XIX, or XX, or the supplemental security income program established by title XVI, (B) any investigation, prosecution, or criminal or civil proceeding, conducted in connection with the administration of any such plan or program, (C) the administration of any other Federal or federally assisted program which provides assistance, in cash or in kind, or services, directly to individuals on the basis of need,[195] (D) any audit or similar activity conducted in connec-

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[194] P.L. 100-485, §202(c)(1), struck out "C, or D of this title" and substituted "or D of this title (including activities under part F)". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

[195] P.L. 101-508, §5054(b)(2)(A), struck out "and".

tion with the administration of any such plan or program by any governmental agency which is authorized by law to conduct such audit or activity, and (E) reporting and providing information pursuant to paragraph (9) to appropriate authorities with respect to known or suspected child abuse or neglect[196]; and the safeguards so provided shall prohibit disclosure, to any committee or legislative body (other than an agency referred to in clause (D) with respect to an activity referred to in such clause), of any information which identifies by name or address any such applicant or recipient; except that nothing contained herein shall preclude a State from providing standards which restrict disclosures to purposes more limited than those specified herein, or which, in the case of adoptions, prevent disclosure entirely;

(9) provides that the State agency will—

(A) report to an appropriate agency or official, known or suspected instances of physical or mental injury, sexual abuse or exploitation, or negligent treatment or maltreatment of a child receiving aid under part B or this part under circumstances which indicate that the child's health or welfare is threatened thereby; and

(B) provide such information with respect to a situation described in subparagraph (A) as the State agency may have;[197]

(10) provides for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for foster family homes and child care institutions which are reasonably in accord with recommended standards of national organizations concerned with standards for such institutions or homes, including standards related to admission policies, safety, sanitation, and protection of civil rights, and provides that the standards so established shall be applied by the State to any foster family home or child care institution receiving funds under this part or part B of this title;

(11) provides for periodic review of the standards referred to in the preceding paragraph and amounts paid as foster care maintenance payments and adoption assistance to assure their continuing appropriateness;

(12) provides for granting an opportunity for a fair hearing before the State agency to any individual whose claim for benefits available pursuant to this part is denied or is not acted upon with reasonable promptness;

(13) provides that the State shall arrange for a periodic and independently conducted audit of the programs assisted under this part and part B of this title, which shall be conducted no less frequently than once every three years;

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[196] P.L. 101-508, §5054(b)(2)(B), added ", and" and subparagraph (E), applicable to benefits for months beginning on or after May 1, 1991.

[197] P.L. 101-508, §5054(b)(1), amended paragraph (9) in its entirety, applicable to benefits for months beginning on or after May 1, 1991. Until then, paragraph (9) read as follows:

"(9) provides that where any agency of the State has reason to believe that the home or institution in which a child resides whose care is being paid for in whole or in part with funds provided under this part or part B of this title is unsuitable for the child because of the neglect, abuse, or exploitation of such child, it shall bring such condition to the attention of the appropriate court or law enforcement agency;".

(14) provides (A) specific goals (which shall be established by State law on or before October 1, 1982) for each fiscal year (commencing with the fiscal year which begins on October 1, 1983) as to the maximum number of children (in absolute numbers or as a percentage of all children in foster care with respect to whom assistance under the plan is provided during such year) who, at any time during such year, will remain in foster care after having been in such care for a period in excess of twenty-four months, and (B) a description of the steps which will be taken by the State to achieve such goals;

(15) effective October 1, 1983, provides that, in each case, reasonable efforts will be made (A) prior to the placement of a child in foster care, to prevent or eliminate the need for removal of the child from his home, and (B) to make it possible for the child to return to his home;

(16) provides for the development of a case plan (as defined in section 475(1)) for each child receiving foster care maintenance payments under the State plan and provides for a case review system which meets the requirements described in section 475(5)(B) with respect to each such child; and[198]

(17) provides that, where appropriate, all steps will be taken, including cooperative efforts with the State agencies administering the plans approved under parts A and D, to secure an assignment to the State of any rights to support on behalf of each child receiving foster care maintenance payments under this part.

(b) The Secretary shall approve any plan which complies with the provisions of subsection (a) of this section. However, in any case in which the Secretary finds, after reasonable notice and opportunity for a hearing, that a State plan which has been approved by the Secretary no longer complies with the provisions of subsection (a), or that in the administration of the plan there is a substantial failure to comply with the provisions of the plan, the Secretary shall notify the State that further payments will not be made to the State under this part, or that such payments will be made to the State but reduced by an amount which the Secretary determines appropriate, until the Secretary is satisfied that there is no longer any such failure to comply, and until he is so satisfied he shall make no further payments to the State, or shall reduce such payments by the amount specified in his notification to the State.

FOSTER CARE MAINTENANCE PAYMENTS PROGRAM[199]

SEC. 472. [42 U.S.C. 672] (a) Each State with a plan approved under this part shall make foster care maintenance payments (as defined in section 475(4)) under this part with respect to a child who would meet the requirements of section 406(a) or of section 407 but for his removal from the home of a relative (specified in section 406(a)), if—

(1) the removal from the home occurred pursuant to a voluntary placement agreement entered into by the child's parent or

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[198] See Vol. II, P.L. 96-272, §102(e), with respect to the Secretary's report to Congress on the number of children placed in foster care pursuant to certain voluntary placement agreements.

[199] See Vol. II, P.L. 96-272, §102(e), with respect to the Secretary's report to Congress on the number of children placed in foster care pursuant to certain voluntary placement agreements.

legal guardian, or was the result of a judicial determination to the effect that continuation therein would be contrary to the welfare of such child and (effective October 1, 1983) that reasonable efforts of the type described in section 471(a)(15) have been made;

(2) such child's placement and care are the responsibility of (A) the State agency administering the State plan approved under section 471, or (B) any other public agency with whom the State agency administering or supervising the administration of the State plan approved under section 471 has made an agreement which is still in effect;

(3) such child has been placed in a foster family home or child-care institution as a result of the voluntary placement agreement or judicial determination referred to in paragraph (1); and

(4) such child—

(A) received aid under the State plan approved under section 402 in or for the month in which such agreement was entered into or court proceedings leading to the removal of such child from the home were initiated, or

(B)(i) would have received such aid in or for such month if application had been made therefor, or (ii) had been living with a relative specified in section 406(a) within six months prior to the month in which such agreement was entered into or such proceedings were initiated, and would have received such aid in or for such month if in such month he had been living with such a relative and application therefor had been made.

In any case where the child is an alien disqualified under section 245A(h), 210(f), or 210A(d)(7) of the Immigration and Nationality Act[200] from receiving aid under the State plan approved under section 402 in or for the month in which such agreement was entered into or court proceedings leading to the removal of the child from the home were instituted, such child shall be considered to satisfy the requirements of paragraph (4) (and the corresponding requirements of section 473(a)(2)(B)), with respect to that month, if he or she would have satisfied such requirements but for such disqualification.

(b) Foster care maintenance payments may be made under this part only on behalf of a child described in subsection (a) of this section who is—

(1) in the foster family home of an individual, whether the payments therefor are made to such individual or to a public or nonprofit private child-placement or child-care agency, or

(2) in a child-care institution, whether the payments therefor are made to such institution or to a public or nonprofit private child-placement or child-care agency, which payments shall be limited so as to include in such payments only those items which are included in the term "foster care maintenance payments" (as defined in section 475(4)).

(c) For the purposes of this part, (1) the term "foster family home" means a foster family home for children which is licensed by the State in which it is situated or has been approved, by the agency of such State having responsibility for licensing homes of this type, as meeting the standards established for such licensing; and (2) the term "child-care institution" means a nonprofit private child-care institution, or a public child-care institution which accommodates no more than twenty-five children, which is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing or approval of institutions of this type, as meeting the standards established for such licensing, but the term shall not include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent.

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[200] P.L. 82-414.

(d) Notwithstanding any other provision of this title, Federal payments may be made under this part with respect to amounts expended by any State as foster care maintenance payments under this section, in the case of children removed from their homes pursuant to voluntary placement agreements as described in subsection (a), only if (at the time such amounts were expended) the State has fulfilled all of the requirements of section 427(b).

(e) No Federal payment may be made under this part with respect to amounts expended by any State as foster care maintenance payments under this section, in the case of any child who was removed from his or her home pursuant to a voluntary placement agreement as described in subsection (a) and has remained in voluntary placement for a period in excess of 180 days, unless there has been a judicial determination by a court of competent jurisdiction (within the first 180 days of such placement) to the effect that such placement is in the best interests of the child.

(f) For the purposes of this part and part B of this title, (1) the term "voluntary placement" means an out-of-home placement of a minor, by or with participation of a State agency, after the parents or guardians of the minor have requested the assistance of the agency and signed a voluntary placement agreement; and (2) the term "voluntary placement agreement" means a written agreement, binding on the parties to the agreement, between the State agency, any other agency acting on its behalf, and the parents or guardians of a minor child which specifies, at a minimum, the legal status of the child and the rights and obligations of the parents or guardians, the child, and the agency while the child is in placement.

(g) In any case where—

(1) the placement of a minor child in foster care occurred pursuant to a voluntary placement agreement entered into by the parents or guardians of such child as provided in subsection (a), and

(2) such parents or guardians request (in such manner and form as the Secretary may prescribe) that the child be returned to their home or to the home of a relative,

the voluntary placement agreement shall be deemed to be revoked unless the State agency opposes such request and obtains a judicial determination, by a court of competent jurisdiction, that the return of the child to such home would be contrary to the child's best interests.

(h) For purposes of titles XIX and XX, any child with respect to whom foster care maintenance payments are made under this section shall be deemed to be a dependent child as defined in section 406 and shall be deemed to be a recipient of aid to families with dependent children under part A of this title. For purposes of the preceding sentence, a child whose costs in a foster family home or child-care institution are covered by the foster care maintenance payments being made with respect to his or her minor parent, as provided in section 475(4)(B), shall be considered a child with respect to whom foster care maintenance payments are made under this section.

ADOPTION ASSISTANCE PROGRAM

SEC. 473. [42 U.S.C. 673] (a)(1)(A) Each State having a plan approved under this part shall enter into adoption assistance agreements (as defined in section 475(3)) with the adoptive parents of children with special needs.

(B) Under any adoption assistance agreement entered into by a State with parents who adopt a child with special needs, the State—

(i) shall make payments of nonrecurring adoption expenses incurred by or on behalf of such parents in connection with the adoption of such child, directly through the State agency or through another public or nonprofit private agency, in amounts determined under paragraph (3), and

(ii) in any case where the child meets the requirements of paragraph (2), may make adoption assistance payments to such parents, directly through the State agency or through another public or nonprofit private agency, in amounts so determined.

(2) For purposes of paragraph (1)(B)(ii), a child meets the requirements of this paragraph if such child—

(A)(i) at the time adoption proceedings were initiated, met the requirements of section 406(a) or section 407 or would have met such requirements except for his removal from the home of a relative (specified in section 406(a)), either pursuant to a voluntary placement agreement with respect to which Federal payments are provided under section 474 (or 403) or as a result of a judicial determination to the effect that continuation therein would be contrary to the welfare of such child,

(ii) meets all of the requirements of title XVI with respect to eligibility for supplemental security income benefits, or

(iii) is a child whose costs in a foster family home or child-care institution are covered by the foster care maintenance payments being made with respect to his or her minor parent as provided in section 475(4)(B),

(B)(i) received aid under the State plan approved under section 402 in or for the month in which such agreement was entered into or court proceedings leading to the removal of such child from the home were initiated, or

(ii)(I) would have received such aid in or for such month if application had been made therefor, or (II) had been living with a relative specified in section 406(a) within six months prior to the month in which such agreement was entered into or such proceedings were initiated, and would have received such aid in or for such month if in such month he had been living with such a relative and application therefor had been made, or

(iii) is a child described in subparagraph (A)(ii) or (A)(iii), and

(C) has been determined by the State, pursuant to subsection (c) of this section, to be a child with special needs.

The last sentence of section 472(a) shall apply, for purposes of subparagraph (B), in any case where the child is an alien described in that sentence.

(3) The amount of the payments to be made in any case under clauses (i) and (ii) of paragraph (1)(B) shall be determined through agreement between the adoptive parents and the State or local agency administering the program under this section, which shall take into consideration the circumstances of the adopting parents and the needs of the child being adopted, and may be readjusted periodically, with the concurrence of the adopting parents (which may be specified in the adoption assistance agreement), depending upon changes in such circumstances. However, in no case may the amount of the adoption assistance payment made under clause (ii) of paragraph (1)(B) exceed the foster care maintenance payment which would have been paid during the period if the child with respect to whom the adoption assistance payment is made had been in a foster family home.

(4) Notwithstanding the preceding paragraph, (A) no payment may be made to parents with respect to any child who has attained the age of eighteen (or, where the State determines that the child has a mental or physical handicap which warrants the continuation of assistance, the age of twenty-one), and (B) no payment may be made to parents with respect to any child if the State determines that the parents are no longer legally responsible for the support of the child or if the State determines that the child is no longer receiving any support from such parents. Parents who have been receiving adoption assistance payments under this section shall keep the State or local agency administering the program under this section informed of circumstances which would, pursuant to this subsection, make them ineligible for such assistance payments, or eligible for assistance payments in a different amount.

(5) For purposes of this part, individuals with whom a child (who has been determined by the State, pursuant to subsection (c), to be a child with special needs) is placed for adoption in accordance with applicable State and local law shall be eligible for such payments, during the period of the placement, on the same terms and subject to the same conditions as if such individuals had adopted such child.

(6)(A) For purposes of paragraph (1)(B)(i), the term "nonrecurring adoption expenses" means reasonable and necessary adoption fees, court costs, attorney fees, and other expenses which are directly related to the legal adoption of a child with special needs and which are not incurred in violation of State or Federal law.

(B) A State's payment of nonrecurring adoption expenses under an adoption assistance agreement shall be treated as an expenditure made for the proper and efficient administration of the State plan for purposes of section 474(a)(3)(B).

(b) For purposes of titles XIX and XX, any child—

(1)(A) who is a child described in subsection (a)(2), and

(B) with respect to whom an adoption assistance agreement is in effect under this section (whether or not adoption assistance payments are provided under the agreement or are being made under this section), including any such child who has been placed for adoption in accordance with applicable State and local law (whether or not an interlocutory or other judicial decree of adoption has been issued), or

(2) with respect to whom foster care maintenance payments are being made under section 472,

shall be deemed to be a dependent child as defined in section 406 and shall be deemed to be a recipient of aid to families with dependent children under part A of this title in the State where such child resides. For purposes of the preceding sentence, a child whose costs in a foster family home or child-care institution are covered by the foster care maintenance payments being made with respect to his or her minor parent, as provided in section 475(4)(B), shall be considered a child with respect to whom foster care maintenance payments are being made under section 472.

(c) For purposes of this section, a child shall not be considered a child with special needs unless—

(1) the State has determined that the child cannot or should not be returned to the home of his parents; and

(2) the State had first determined (A) that there exists with respect to the child a specific factor or condition (such as his ethnic background, age, or membership in a minority or sibling group, or the presence of factors such as medical conditions or physical, mental, or emotional handicaps) because of which it is reasonable to conclude that such child cannot be placed with adoptive parents without providing adoption assistance under this section or medical assistance under title XIX, and (B) that, except where it would be against the best interests of the child because of such factors as the existence of significant emotional ties with prospective adoptive parents while in the care of such parents as a foster child, a reasonable, but unsuccessful, effort has been made to place the child with appropriate adoptive parents without providing adoption assistance under this section or medical assistance under title XIX.

PAYMENTS TO STATES; ALLOTMENTS TO STATES[201]

SEC. 474. [42 U.S.C. 674] (a) For each quarter beginning after September 30, 1980, each State which has a plan approved under this part (subject to the limitations imposed by subsection (b)) shall be entitled to a payment equal to the sum of—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b) of this Act) of the total amount expended during such quarter as foster care maintenance payments under section 472 for children in foster family homes or child-care institutions; plus

(2) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b) of this Act) of the total amount expended during such quarter as adoption assistance payments under section 473 pursuant to adoption assistance agreements; plus

(3) an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary for the provision of child placement services and for the[202] proper and efficient administration of the State plan—

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[201] See Vol. II, P.L. 99-177, §256 , with respect to treatment of foster care and adoption assistance programs.

[202] P.L. 101-508, §5071(a), inserted "provision of child placement services and for the", effective November 5, 1990.

(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision,[203]

(B) 75 percent of so much of such expenditures (including travel and per diem expenses) as are for the short-term training of current or prospective foster or adoptive parents and the members of the staff of State-licensed or State-approved child care institutions providing care to foster and adopted children receiving assistance under this part, in ways that increase the ability of such current or prospective parents, staff members, and institutions to provide support and assistance to foster and adopted children, whether incurred directly by the State or by contract, and[204]

(C)[205] one-half of the remainder of such expenditures; plus

(4) an amount equal to the sum of—

(A) so much of the amounts expended by such State to carry out programs under section 477 as do not exceed the basic amount for such State determined under section 477(e)(1); and

(B) the lesser of—

(i) one-half of any additional amounts expended by such State for such programs; or

(ii) the maximum additional amount for such State under such section 477(e)(1).[206]

(b)(1) Notwithstanding the provisions of subsections (a)(1) and (a)(3), the aggregate of the sums payable thereunder to any State (other than a State subject to limitation under section 1108(a)) with respect to expenditures relating to foster care, for the calendar quarters in any of the fiscal years 1981 through 1992[207] in which the conditions set forth in paragraph (2) are met, shall not exceed the State's allotment for such year.

(2)(A) The limitation in paragraph (1) shall apply—

(i) with respect to fiscal year 1981, only if the amount appropriated under section 420 for such fiscal year is equal to or greater than $163,550,000;

(ii) with respect to fiscal year 1982, only if the amount appropriated under section 420 for such fiscal year is equal to or greater than $220,000,000;[208]

(iii) with respect to each of the fiscal years 1983 through 1989, only if the amount appropriated under section 420 for such fiscal year is equal to $266,000,000; and[209]

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[203] P.L. 101-239, §8006(a)(1), struck out "and".

[204] P.L 101-239, §8006(a)(3), added this subparagraph, applicable to expenditures made on or after October 1, 1989, and before October 1, 1992.

[205] P.L. 101-239, §8006(a)(2), redesignated subparagraph (B) as subparagraph (C), applicable to expenditures made on or after October 1, 1989, and before October 1, 1992.

[206] P.L. 101-239, §8002(c), amended paragraph (4) in its entirety, effective October 1, 1989. [For paragraph (4) as it formerly read, see Vol. III, P.L. 101-239.]

[207] P.L. 101-239, §8001(a), struck out "1989" and substituted "1992", effective October 1, 1989.

[208] P.L. 101-239, §10402(a)(1), struck out "and".

[209] P.L. 101-239, §10402(a)(2), struck out the period and substituted "; and".

(iv) with respect to each fiscal year succeeding the fiscal year 1989, only if $325,000,000 is appropriated under section 420 for such succeeding fiscal year.[210]

(B) The limitations set forth in paragraph (1) with respect to the fiscal years 1981 through 1992[211] shall apply only if the required appropriation is made in advance in an appropriation Act (as authorized under section 420(b)) for the fiscal year preceding the fiscal year to which the limitation would apply.

(3) For purposes of this subsection, a State's allotment for any fiscal year shall be the greater of—

(A) the amount determined under paragraph (4);

(B) an amount which bears the same ratio to $100,000,000 as the under age eighteen population of such State bears to the under age eighteen population of the fifty States and the District of Columbia; or

(C) at the option of the State, an amount determined under paragraph (5), but only in the case of a State which meets the requirements of such paragraph (5).

(4) For purposes of paragraph (3)(A), a State's allotment shall be determined as follows:

(A) The allotment for any State for fiscal year 1980 shall be an amount equal to such State's base amount (as determined under subparagraph (C)) increased by 21.2 percent.

(B) The allotment for any State for each of the fiscal years 1981 through 1992[212] shall be an amount equal to such State's allotment for the preceding fiscal year, increased or decreased by a percentage equal to twice the percentage increase or decrease (as the case may be) (but not to exceed an increase or decrease of 10 percent) in the Consumer Price Index prepared by the Department of Labor, and used in determining cost-of-living adjustments under section 215(i) of this Act, for the second quarter of the preceding fiscal year as compared to such index for the second quarter of the second preceding fiscal year. For purposes of this subparagraph the Consumer Price Index for any quarter shall be the arithmetical mean of such index for the three months in such quarter.

(C) The base amount shall be equal to the amount of the Federal funds payable to such State for fiscal year 1978 under section 403 on account of expenditures for aid with respect to which Federal financial participation is authorized in payments pursuant to section 408[213] (including administrative expenditures attributable to the provision of such aid as determined by the Secretary) and for those States which in fiscal year 1978 did not make foster care maintenance payments under section 408[214] on behalf of children otherwise eligible for such payment, solely because their foster care was provided by related persons, shall be equal to the total amount of Federal funds the State would have been entitled to be paid under section 403 on account of expenditures pursuant to section 408[215] for that fiscal year if such payments had been made. In the event that there is a dispute between any State and the Secretary as to the amount of such expenditures for such fiscal year, then, until the beginning of the fiscal year immediately following the fiscal year in which the dispute is finally resolved, the base amount shall be deemed to be the amount of Federal funds which would have been payable under section 403 if the amount of such expenditures were equal to the amount thereof claimed by the State.

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[210] P.L. 101-239, §10402(a)(3), added this clause, effective October 1, 1989.

[211] P.L. 101-239, §8001(a), struck out "1989" and substituted "1992", effective October 1, 1989.

[212] P.L. 101-239, §8001(a), struck out "1989" and substituted "1992", effective October 1, 1989.

[213] This reference is to §408 as it read before repealed by P.L. 96-272, §101(a)(2)(A); 94 Stat. 512.

[214] This reference is to §408 as it read before repealed by P.L. 96-272, §101(a)(2)(A); 94 Stat. 512.

[215] This reference is to §408 as it read before repealed by P.L. 96-272, §101(a)(2)(A); 94 Stat. 512.

(5)(A) For purposes of paragraph (3)(C), a State's allotment for any fiscal year ending after September 30, 1980, and before October 1, 1992[216], may, at the option of the State (and if the State meets the requirements of subparagraphs (B) and (C)), be determined by application of the provisions of paragraph (4) with the following modifications:

(i) The base amount for purposes of determining an allotment for any such fiscal year shall be equal to the base amount determined under paragraph (4)(C) increased by a percentage equal to the percentage by which the average monthly number of children in such State receiving aid with respect to which Federal financial participation is authorized in payments pursuant to section 408[217], or receiving foster care maintenance payments with respect to which Federal financial participation is authorized under this part, for such fiscal year exceeds the average monthly number of such children for fiscal year 1978.

(ii) For purposes of clause (i), the percentage determined under such clause shall not exceed 33.1 percent in the case of fiscal year 1981, 46.4 percent in the case of fiscal year 1982, 61.1 percent in the case of fiscal year 1983, or 77.2 percent in the case of each of fiscal years 1984 through 1992[218].

(B) No State may exercise the option to have its allotment amount determined under the provisions of this paragraph unless, for fiscal year 1978, the average monthly number of children in such State receiving aid for which Federal financial participation is authorized in payments pursuant to section 408[219] as a percentage of the under age eighteen population of such State, was less than the average such percentage for the fifty States and the District of Columbia.

(C) No State may exercise the option to have its allotment determined under this paragraph for any fiscal year other than fiscal year 1981 after the first fiscal year (after fiscal year 1978) with respect to which the average monthly number of children in such State receiving aid for which Federal financial participation is authorized in payments pursuant to section 408[220] or receiving foster care maintenance payments for which Federal financial participation is authorized under this part, as a percentage of the under age eighteen population of such State, was equal to or greater than the average such percentage for the fifty States and the District of Columbia for the fiscal year 1978. Any allotment determined under this paragraph for a State which opted to have its allotment so determined under this paragraph for the fiscal year prior to the first fiscal year for which its option may not be exercised by reason of the preceding sentence shall be considered to be such State's allotment for such prior fiscal year for purposes of determining allotments for subsequent fiscal years under paragraph (4).

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[216] P.L. 101-239, §8001(a), struck out "1989" and substituted "1992", effective October 1, 1989.

[217] This reference is to §408 as it read before repealed by P.L. 96-272, §101(a)(2)(A); 94 Stat. 512.

[218] P.L. 101-239, §8001(a), struck out "1989" and substituted "1992", effective October 1, 1989.

[219] This reference is to §408 as it read before repealed by P.L. 96-272, §101(a)(2)(A); 94 Stat. 512.

[220] This reference is to §408 as it read before repealed by P.L. 96-272, §101(a)(2)(A); 94 Stat. 512.

(D) In determining the number of children receiving aid for which Federal financial participation is authorized in payments under section 408[221] or under this part, for any fiscal year, with respect to any State and with respect to the national average for purposes of subparagraphs (B) and (C), there shall be included those children with respect to whom foster care maintenance payments were not made under section 408[222] or this part (though they were otherwise eligible for such payments) solely because their foster care was provided by related persons. In the event that there is a dispute between any State and the Secretary as to the number of such children (with respect to whom foster care maintenance payments were not made) for any fiscal year, then until the beginning of the fiscal year immediately following the fiscal year in which the dispute is finally resolved, determinations under subparagraphs (B) and (C) shall be made on the basis of the number of such children claimed by the State.

(E) The Secretary shall promulgate an interim allotment amount for purposes of this paragraph for each fiscal year for each State exercising its option to have its allotment determined under this paragraph, based on the most recent satisfactory data available, not later than six months after the beginning of such fiscal year. The amount of such allotment shall be adjusted, and the final allotment amount shall be promulgated, based on the most recent satisfactory data available, not later than nine months after the end of such fiscal year.

(6) Except in the case of a State which loses the option of having its allotment determined under paragraph (5) by reason of the provisions of paragraph (5)(C), and subject to the provisions of such paragraph (5)(C), the amount of any allotment as determined in accordance with subparagraph (A), (B), or (C) of paragraph (3) for any fiscal year for any State shall be determined in accordance with the provisions of such subparagraph, without regard to the amount of such State's allotment for any prior fiscal year as determined in accordance with another such subparagraph.

(c)(1) Except as provided in paragraphs (3) and (4), for any of the fiscal years 1981 through 1992[223] during which the limitation under subsection (b)(1) is in effect, sums available to a State from its allotment under subsection (b) for carrying out this part, which the State does not claim as reimbursement for expenditures in such year pursuant to subsection (a) of this section, may be claimed by the State as reimbursement for expenditures in such year pursuant to part B of this title, in addition to sums available pursuant to section 420 for carrying out part B.

(2) Except as provided in paragraphs (3) and (4), for any of the fiscal years 1981 through 1992[224] during which the limitation under subsection (b)(1) is not in effect, a State may claim as reimbursement for expenditures for such year pursuant to part B of this title, in

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[221] This reference is to §408 as it read before repealed by P.L. 96-272, §101(a)(2)(A); 94 Stat. 512.

[222] This reference is to §408 as it read before repealed by P.L. 96-272, §101(a)(2)(A); 94 Stat. 512.

[223] P.L. 101-239, §8001(a), struck out "1989" and substituted "1992", effective October 1, 1989.

[224] P.L. 101-239, §8001(a), struck out "1989" and substituted "1992", effective October 1, 1989.

addition to amounts claimed under section 420, an amount equal to the amount by which the State's allotment amount for such fiscal year (as determined under subsection (b)(3)) exceeds the amount claimed by such State for such fiscal year as reimbursement for expenses relating to foster care under subsection (a); except that the total amount claimed by such State for such fiscal year under this paragraph, when added to the amount that such State receives for such fiscal year under section 420, may not exceed the amount that would have been payable to such State under section 420 for such fiscal year if the relevant amount described in subsection (b)(2)(A) had been appropriated for such fiscal year.

(3) The provisions of paragraphs (1) and (2) shall not apply for any fiscal year with respect to any State which, with respect to such fiscal year, exercised its option to have its allotment amount determined under subsection (b)(5).

(4)(A) No State may claim an amount under the provisions of this subsection as reimbursement for expenditures for any fiscal year pursuant to part B of this title to the extent that such amount, plus the amount claimed by such State for such fiscal year under section 420, exceeds the amount which would be allotted to such State under part B if the amount appropriated under section 420 were $141,000,000, unless such State has met the requirements set forth in section 427(a).

(B) If, for each of any two consecutive fiscal years, there is appropriated under section 420 a sum equal to $325,000,000[225], no State may claim any amount under the provisions of this subsection as reimbursement for expenditures for any succeeding fiscal year pursuant to part B of this title unless such State has met the requirements set forth in section 427(b).

(C) If, for each of any two fiscal years during which the limitation under subsection (b)(1) is not in effect, the total amount claimed by a State as reimbursement for expenditures pursuant to part B under this subsection and under section 420 equals the amount which would be allotted to such State for such fiscal year under part B if the amount appropriated under section 420 were $325,000,000[226], such State may not claim any amount under the provisions of paragraph (2) as reimbursement for expenditures for any succeeding fiscal year pursuant to part B of this title unless such State has met the requirements set forth in section 427(b).

(d)(1) The Secretary shall, prior to the beginning of each quarter, estimate the amount to which a State will be entitled under subsections (a), (b), and (c) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of children in the State receiving assistance under this part, and (C) such other investigation as the Secretary may find necessary.

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[225] P.L. 101-239, §10401(a), struck out "$266,000,000" and substituted "$325,000,000", effective October 1, 1989.

[226] P.L. 101-239, §10401(a), struck out "$266,000,000" and substituted "$325,000,000", effective October 1, 1989.

(2) The Secretary shall then pay to the State, in such installments as he may determine, the amounts so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to foster care and adoption assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

DEFINITIONS

SEC. 475. **[**42 U.S.C. 675**]** As used in this part or part B of this title:

(1) The term "case plan" means a written document which includes at least the following:

(A)[227] A description of the type of home or institution in which a child is to be placed, including a discussion of the appropriateness of the placement and how the agency which is responsible for the child plans to carry out the voluntary placement agreement entered into or judicial determination made with respect to the child in accordance with section 472(a)(1).[228]

(B) A[229] plan for assuring that the child receives proper care and that services are provided to the parents, child, and foster parents in order to improve the conditions in the parents' home, facilitate return of the child to his own home or the permanent placement of the child, and address the needs of the child while in foster care, including a discussion of the appropriateness of the services that have been provided to the child under the plan.

(C) To the extent available and accessible, the health and education records of the child, including—

(i) the names and addresses of the child's health and educational providers;

(ii) the child's grade level performance;

(iii) the child's school record;

(iv) assurances that the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement;

(v) a record of the child's immunizations;

(vi) the child's known medical problems;

(vii) the child's medications; and

(viii) any other relevant health and education information concerning the child determined to be appropriate by the State agency.[230]

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[227] P.L. 101-239, §8007(a)(1), inserted "(A)".

[228] P.L. 101-239, §8007(a)(3), moved subparagraph (A) 4 ems to the right, effective April 1, 1990, and §8007(a)(2), struck out "; and" and substituted a period, effective April 1, 1990.

[229] P.L. 101-239, §8007(a)(2), struck out "a" and substituted "(B) A" and §8007(a)(3) moved subparagraph (B) 4 ems to the right, effective April 1, 1990.

[230] P.L. 101-239, §8007(a)(4), added subparagraph (C), effective April 1, 1990.

Where appropriate, for a child age 16 or over, the case plan must also include a written description of the programs and services which will help such child prepare for the transition from foster care to independent living.[231]

(2) The term "parents" means biological or adoptive parents or legal guardians, as determined by applicable State law.

(3) The term "adoption assistance agreement" means a written agreement, binding on the parties to the agreement, between the State agency, other relevant agencies, and the prospective adoptive parents of a minor child which at a minimum (A) specifies the nature and amount of any payments, services, and assistance to be provided under such agreement, and (B) stipulates that the agreement shall remain in effect regardless of the State of which the adoptive parents are residents at any given time. The agreement shall contain provisions for the protection (under an interstate compact approved by the Secretary or otherwise) of the interests of the child in cases where the adoptive parents and child move to another State while the agreement is effective.

(4)(A) The term "foster care maintenance payments" means payments to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation. In the case of institutional care, such term shall include the reasonable costs of administration and operation of such institution as are necessarily required to provide the items described in the preceding sentence.

(B) In cases where—

(i) a child placed in a foster family home or child-care institution is the parent of a son or daughter who is in the same home or institution, and

(ii) payments described in subparagraph (A) are being made under this part with respect to such child,

the foster care maintenance payments made with respect to such child as otherwise determined under subparagraph (A) shall also include such amounts as may be necessary to cover the cost of the items described in that subparagraph with respect to such son or daughter.

(5) The term "case review system" means a procedure for assuring that—

(A) each child has a case plan designed to achieve placement in the least restrictive (most family like) setting available and in close proximity to the parents' home, consistent with the best interest and special needs of the child,

(B) the status of each child is reviewed periodically but no less frequently than once every six months by either a court or by administrative review (as defined in paragraph (6)) in order to determine the continuing necessity for and appropriateness of the placement, the extent of compliance with the case plan, and the extent of progress which has been made toward alleviating or mitigating the causes necessitating placement in foster care, and to project a likely date by which the child may be returned to the home or placed for adoption or legal guardianship,[232]

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[231] P.L 101-239, §8007(a)(5), realigned last sentence with left margin of the paragraph.

(C) with respect to each such child, procedural safeguards will be applied, among other things, to assure each child in foster care under the supervision of the State of a dispositional hearing to be held, in a family or juvenile court or another court (including a tribal court) of competent jurisdiction, or by an administrative body appointed or approved by the court, no later than eighteen months after the original placement (and periodically thereafter during the continuation of foster care), which hearing shall determine the future status of the child (including, but not limited to, whether the child should be returned to the parent, should be continued in foster care for a specified period, should be placed for adoption, or should (because of the child's special needs or circumstances) be continued in foster care on a permanent or long-term basis) and, in the case of a child who has attained age 16, the services needed to assist the child to make the transition from foster care to independent living; and procedural safeguards shall also be applied with respect to parental rights pertaining to the removal of the child from the home of his parents, to a change in the child's placement, and to any determination affecting visitation privileges of parents; and[233]

(D) a child's health and education record (as described in paragraph (1)(A)) is reviewed and updated, and supplied to the foster parent or foster care provider with whom the child is placed, at the time of each placement of the child in foster care.[234]

(6) The term "administrative review" means a review open to the participation of the parents of the child, conducted by a panel of appropriate persons at least one of whom is not responsible for the case management of, or the delivery of services to, either the child or the parents who are the subject of the review.

TECHNICAL ASSISTANCE; DATA COLLECTION AND EVALUATION

SEC. 476. [42 U.S.C. 676] (a) The Secretary may provide technical assistance to the States to assist them to develop the programs authorized under this part and shall periodically (1) evaluate the programs authorized under this part and part B of this title and (2) collect and publish data pertaining to the incidence and characteristics of foster care and adoptions in this country.

(b) Each State shall submit statistical reports as the Secretary may require with respect to children for whom payments are made under this part containing information with respect to such children including legal status, demographic characteristics, location, and length of any stay in foster care.

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[232] P.L. 101-239, §8007(b)(1), struck out "and".

[233] P.L. 101-239, §8007(b)(2), struck out the period and substituted "; and".

[234] P.L. 101-239, §8007(b)(3), added subparagraph (D), effective April 1, 1990. Alinement as in original.

INDEPENDENT LIVING INITIATIVES[235]

SEC. 477. [42 U.S.C. 677] (a)(1) Payments shall be made in accordance with this section for the purpose of assisting States and localities in establishing and carrying out programs designed to assist children described in paragraph (2) who have attained age 16 in making the transition from foster care to independent living. Any State which provides for the establishment and carrying out of one or more such programs in accordance with this section for a fiscal year shall be entitled to receive payments under this section for such fiscal year, in an amount determined under subsection (e). Such payments shall be made only for the fiscal years 1987 through 1992[236].

(2) A program established and carried out under paragraph (1)—

(A) shall be designed to assist children with respect to whom foster care maintenance payments are being made by the State under this part,

(B) may at the option of the State also include any or all other children in foster care under the responsibility of the State, and

(C) may at the option of the State also include any child who has not attained age 21[237] to whom foster care maintenance payments were previously made by a State under this part and whose payments were discontinued on or after the date such child attained age 16, and any child who previously was in foster care described in subparagraph (B) and for whom such care was discontinued on or after the date such child attained age 16[238]; and a written transitional independent living plan of the type described in subsection (d)(6) shall be developed for such child as a part of such program.

(b) The State agency administering or supervising the administration of the State's programs under this part shall be responsible for administering or supervising the administration of the State's programs described in subsection (a). Payment under this section shall be made to the State, and shall be used for the purpose of conducting and providing in accordance with this section (directly or under contracts with local governmental entities or private nonprofit organizations) the activities and services required to carry out the program or programs involved.

(c) In order for a State to receive payments under this section for any fiscal year, the State agency must submit to the Secretary, in such manner and form as the Secretary may prescribe, a description of the program together with satisfactory assurances that the program will be operated in an effective and efficient manner and will otherwise meet the requirements of this section. In the case of payments for fiscal year 1987, such description and assurances must be submitted within 90 days after the Secretary promulgates regulations as required under subsection (i), and in the case of payments for any of the fiscal years 1988 through 1992[239], such description and assurances must be submitted prior to February 1 of such fiscal year.

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[235] See Vol. II, P.L. 101-239, §8002(d), with respect to a study and report by the Secretary.

[236] P.L. 101-239, §8002(a)(1), struck out ", 1988, and 1989" and substituted "through 1992", effective October 1, 1989.

[237] P.L. 101-508, §5073(a)(1), inserted "who has not attained age 21", applicable to payments made under part E of this title for fiscal years beginning in or after fiscal year 1991.

[238] P.L. 101-508, §5073(a)(2), struck out ", but such child may not be so included after the end of the 6-month period beginning on the date of discontinuance of such payments or care", applicable to payments made under part E of this title for fiscal years beginning in or after fiscal year 1991.

[239] P.L. 101-239, §8002(a)(2), struck out "the fiscal year 1988 or 1989" and substituted "any of the fiscal years 1988 through 1992", effective October 1, 1989.

(d) In carrying out the purpose described in subsection (a), it shall be the objective of each program established under this section to help the individuals participating in such program to prepare to live independently upon leaving foster care. Such programs may include (subject to the availability of funds) programs to—

(1) enable participants to seek a high school diploma or its equivalent or to take part in appropriate vocational training;

(2) provide training in daily living skills, budgeting, locating and maintaining housing, and career planning;

(3) provide for individual and group counseling;

(4) integrate and coordinate services otherwise available to participants;

(5) provide for the establishment of outreach programs designed to attract individuals who are eligible to participate in the program;

(6) provide each participant a written transitional independent living plan which shall be based on an assessment of his needs, and which shall be incorporated into his case plan, as described in section 475(1); and

(7) provide participants with other services and assistance designed to improve their transition to independent living.

(e)(1)(A)[240] The basic[241] amount to which a State shall be entitled under section 474(a)(4) for each of the fiscal years 1987 through 1992[242] shall be an amount which bears the same ratio to the basic ceiling for such fiscal year[243] as such State's average number of children receiving foster care maintenance payments under this part in fiscal year 1984 bears to the total of the average number of children receiving such payments under this part for all States for fiscal year 1984.

(B) The maximum additional amount to which a State shall be entitled under section 474(a)(4) for fiscal years 1991 and 1992 shall be an amount which bears the same ratio to the additional ceiling for such fiscal year as the basic amount of such State bears to $45,000,000.[244]

(C) As used in this section:

(i) The term "basic ceiling" means—

(I) for fiscal year 1990, $50,000,000; and

(II) for each fiscal year other than fiscal year 1990, $45,000,000.

(ii) The term "additional ceiling" means—

(I) for fiscal year 1991, $15,000,000; and

(II) for fiscal year 1992, $25,000,000.[245]

(2) If any State does not apply for funds under this section for any fiscal year within the time provided in subsection (c), the funds to

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[240] P.L. 101-239, §8002(b)(1), inserted "(A)", effective October 1, 1989.

[241] P.L. 101-239, §8002(b)(2), inserted "basic", effective October 1, 1989.

[242] P.L. 101-239, §8002(a)(1), struck out ", 1988, and 1989" and substituted "through 1992", effective October 1, 1989.

P.L. 101-239, §8002(b)(3), struck out "and 1989" and substituted "1989, 1990, 1991, and 1992", effective October 1, 1989.

P.L. 101-239, §8002(b)(3), appears to duplicate the amendment made by P.L. 101-239, §8002(a)(1).

[243] P.L. 101-239, §8002(b)(4), struck out "$45,000,000" and substituted "the basic ceiling for such fiscal year", effective October 1, 1989.

[244] P.L. 101-239, §8002(b)(5), added subparagraph (B), effective October 1, 1989.

[245] P.L. 101-239, §8002(b)(5), added subparagraph (C), effective October 1, 1989.

which such State would have been entitled for such fiscal year shall be reallocated to one or more other States on the basis of their relative need for additional payments under this section (as determined by the Secretary).

(3) Any amounts payable to States under this section shall be in addition to amounts payable to States under subsections (a)(1), (a)(2), and (a)(3) of section 474, and shall supplement and not replace any other funds which may be available for the same general purposes in the localities involved. Amounts payable under this section may not be used for the provision of room or board.

(f) Payments made to a State under this section for any fiscal year—

(1) shall be used only for the specific purposes described in this section;

(2) may be made on an estimated basis in advance of the determination of the exact amount, with appropriate subsequent adjustments to take account of any error in the estimates; and

(3) shall be expended by such State in such fiscal year or in the succeeding fiscal year.

Notwithstanding paragraph (3), payments made to a State under this section for the fiscal year 1987 and unobligated may be expended by such State in the fiscal year 1989.

(g)(1) Not later than the first January 1 following the end of each fiscal year, each State shall submit to the Secretary a report on the programs carried out during such fiscal year with the amounts received under this section. Such report—

(A) shall be in such form and contain such information as may be necessary to provide an accurate description of such activities, to provide a complete record of the purposes for which the funds were spent, and to indicate the extent to which the expenditure of such funds succeeded in accomplishing the purpose described in subsection (a); and

(B) shall specifically contain such information as the Secretary may require in order to carry out the evaluation under paragraph (2).

(2)(A) Not later than July 1, 1988, the Secretary shall submit an interim report on the activities carried out under this section.

(B) Not later than March 1, 1989, the Secretary, on the basis of the reports submitted by States under paragraph (1) for the fiscal years 1987 and 1988, and on the basis of such additional information as the Secretary may obtain or develop, shall evaluate the use by States of the payments made available under this section for such fiscal year with respect to the purpose of this section, with the objective of appraising the achievements of the programs for which such payments were made available, and developing comprehensive information and data on the basis of which decisions can be made with respect to the improvement of such programs and the necessity for providing further payments in subsequent years. The Secretary shall report such evaluation to the Congress. As a part of such evaluation, the Secretary shall include, at a minimum, a detailed overall description of the number and characteristics of the individuals served by the programs, the various kinds of activities conducted and services provided and the results achieved, and shall set forth in detail findings and comments with respect to the various State programs and a statement of plans and recommendations for the future.

(h) Notwithstanding any other provision of this title, payments made and services provided to participants in a program under this section, as a direct consequence of their participation in such program, shall not be considered as income or resources for purposes of determining eligibility (or the eligibility of any other persons) for aid under the State's plan approved under section 402 or 471, or for purposes of determining the level of such aid.

(i) The Secretary shall promulgate final regulations for implementing this section within 60 days after the date of the enactment of this section[246].

[SEC. 478. Repealed.[247]]

COLLECTION OF DATA RELATING TO ADOPTION AND FOSTER CARE[248]

SEC. 479. [42 U.S.C. 679] (a)(1) Not later than 90 days after the date of the enactment of this subsection[249], the Secretary shall establish an Advisory Committee on Adoption and Foster Care Information (in this section referred to as the "Advisory Committee") to study the various methods of establishing, administering, and financing a system for the collection of data with respect to adoption and foster care in the United States.

(2) The study required by paragraph (1) shall—

(A) identify the types of data necessary to—

(i) assess (on a continuing basis) the incidence, characteristics, and status of adoption and foster care in the United States, and

(ii) develop appropriate national policies with respect to adoption and foster care;

(B) evaluate the feasibility and appropriateness of collecting data with respect to privately arranged adoptions and adoptions arranged through private agencies without assistance from public child welfare agencies;

(C) assess the validity of various methods of collecting data with respect to adoption and foster care; and

(D) evaluate the financial and administrative impact of implementing each such method.

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[246] This section was enacted on April 7, 1986. [P.L. 99-272, 12307(a); 100 Stat. 294]

[247] P.L. 101-508, §5052(b), repealed §478, applicable to benefits for months beginning on or after May 1, 1991. Until then, §478 read as follows:

"EXCLUSION FROM AFDC UNIT OF CHILD FOR WHOM FOSTER CARE MAINTENANCE PAYMENTS ARE MADE

"SEC. 478. Notwithstanding any other provision of this title, a child with respect to whom foster care maintenance payments are made under this part shall not, for the period for which such payments are made, be regarded as a member of a family for purposes of determining the amount of the benefits of the family under part A, and the income and resources of such child shall not be counted as the income and resources of a family under such part.".

See Vol. II, P.L. 99-514, §1883(b)(11), with respect to the effect of the failure of a State to comply with certain provisions or the imposition by a State of a requirement inconsistent with certain provisions.

[248] See Vol. II, P.L. 99-509, §9442, with respect to the maternal and child health and adoption clearinghouse.

[249] This subsection was enacted October 21, 1986. [P.L. 99-509, §9443; 100 Stat. 2073]

(3) Not later than October 1, 1987, the Advisory Committee shall submit to the Secretary and the Congress a report setting forth the results of the study required by paragraph (1) and evaluating and making recommendations with respect to the various methods of establishing, administering, and financing a system for the collection of data with respect to adoption and foster care in the United States.

(4)(A) Subject to subparagraph (B), the membership and organization of the Advisory Committee shall be determined by the Secretary.

(B) The membership of the Advisory Committee shall include representatives of—

(i) private, nonprofit organizations with an interest in child welfare (including organizations that provide foster care and adoption services),

(ii) organizations representing State and local governmental agencies with responsibility for foster care and adoption services,

(iii) organizations representing State and local governmental agencies with responsibility for the collection of health and social statistics,

(iv) organizations representing State and local judicial bodies with jurisdiction over family law,

(v) Federal agencies responsible for the collection of health and social statistics, and

(vi) organizations and agencies involved with privately arranged or international adoptions.

(5) After the date of the submission of the report required by paragraph (3), the Advisory Committee shall cease to exist.

(b)(1)(A) Not later than July 1, 1988, the Secretary shall submit to the Congress a report that—

(i) proposes a method of establishing, administering, and financing a system for the collection of data relating to adoption and foster care in the United States,

(ii) evaluates the feasibility and appropriateness of collecting data with respect to privately arranged adoptions and adoptions arranged through private agencies without assistance from public child welfare agencies, and

(iii) evaluates the impact of the system proposed under clause (i) on the agencies with responsibility for implementing it.

(B) The report required by subparagraph (A) shall—

(i) specify any changes in law that will be necessary to implement the system proposed under subparagraph (A)(i), and

(ii) describe the type of system that will be implemented under paragraph (2) in the absence of such changes.

(2) Not later than December 31, 1988, the Secretary shall promulgate final regulations providing for the implementation of—

(A) the system proposed under paragraph (1)(A)(i), or

(B) if the changes in law specified pursuant to paragraph (1)(B)(i) have not been enacted, the system described in paragraph (1)(B)(ii).

Such regulations shall provide for the full implementation of the system not later than October 1, 1991.

(c) Any data collection system developed and implemented under this section shall—

(1) avoid unnecessary diversion of resources from agencies responsible for adoption and foster care;

(2) assure that any data that is collected is reliable and consistent over time and among jurisdictions through the use of uniform definitions and methodologies;

(3) provide comprehensive national information with respect to—

(A) the demographic characteristics of adoptive and foster children and their biological and adoptive or foster parents,

(B) the status of the foster care population (including the number of children in foster care, length of placement, type of placement, availability for adoption, and goals for ending or continuing foster care),

(C) the number and characteristics of—

(i) children placed in or removed from foster care, and

(ii) children adopted or with respect to whom adoptions have been terminated, and

(D) the extent and nature of assistance provided by Federal, State, and local adoption and foster care programs and the characteristics of the children with respect to whom such assistance is provided; and

(4) utilize appropriate requirements and incentives to ensure that the system functions reliably throughout the United States.

PART F—JOB OPPORTUNITIES AND BASIC SKILLS TRAINING PROGRAM[250]

PURPOSE AND DEFINITIONS

SEC. 481. [42 U.S.C. 681] (a) PURPOSE.—It is the purpose of this part to assure that needy families with children obtain the education, training, and employment that will help them avoid long-term welfare dependence.

(b) MEANING OF TERMS.—Except to the extent otherwise specifically indicated, terms used in this part shall have the meanings given them in or under part A.

ESTABLISHMENT AND OPERATION OF STATE PROGRAMS

SEC. 482. [42 U.S.C. 682] (a) STATE PLANS FOR JOB OPPORTUNITIES AND BASIC SKILLS TRAINING PROGRAMS.—(1)(A) As a condition of its participation in the program of aid to families with dependent children under part A, each State shall establish and operate a job opportunities and basic skills training program (in this part referred to as the "program") under a plan approved by the Secretary as meeting all of the requirements of this part and section 402(a)(19), and shall, in accordance with regulations prescribed by the Secretary, periodically (but not less frequently than every 2 years) review and update its plan and submit the updated plan for approval by the Secretary.

(B) A State plan for establishing and operating the program must describe how the State intends to implement the program during the period covered by the plan, and must indicate, through cross-references to the appropriate provisions of this part and part A, that the program will be operated in accordance with such provision of law. In addition, such plan must contain (i) an estimate of the number of persons to be served by the program, (ii) a description of the services to be provided within the State and the political subdivisions thereof, the needs to be addressed through the provision of such services, the extent to which such services are expected to be made available by other agencies on a nonreimbursable basis, and the extent to which such services are to be provided or funded by the program, and (iii) such additional information as the Secretary may require by regulation to enable the Secretary to determine that the State program will meet all of the requirements of this part and part A.

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[250] P.L. 100-485, §201(b), added part F (§§481-486). For the effective date for §§481-485, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

See Vol. II, P.L. 100-485, §203(a), with respect to regulations, performance standards, and studies relating to job opportunities and basic skills training; §203(c), with respect to implementation and effectiveness studies relating to job opportunities and basic skills training; and §203(d), with respect to a study on application of jobs programs to Indians.

(C) The Secretary shall consult with the Secretary of Labor on general plan requirements and on criteria to be used in approving State plans under this section.

(D)(i) Not later than October 1, 1992, each State shall make the program available in each political subdivision of such State where it is feasible to do so, after taking into account the number of prospective participants, the local economy, and other relevant factors.

(ii) If a State determines that it is not feasible to make the program available in each such subdivision, the State plan must provide appropriate justification to the Secretary.

(2) The State agency that administers or supervises the administration of the State's plan approved under section 402 shall be responsible for the administration or supervision of the administration of the State's program.

(3) Federal funds made available to a State for purposes of the program shall not be used to supplant non-Federal funds for existing services and activities which promote the purpose of this part. State or local funds expended for such purpose shall be maintained at least at the level of such expenditures for the fiscal year 1986.

(b) ASSESSMENT AND REVIEW OF NEEDS AND SKILLS OF PARTICIPANTS; EMPLOYABILITY PLAN.—(1)(A) The State agency must make an initial assessment of the educational, child care, and other supportive services needs as well as the skills, prior work experience, and employability of each participant in the program under this part, including a review of the family circumstances. The agency may also review the needs of any child of the participant.

(B) On the basis of such assessment, the State agency, in consultation with the participant, shall develop an employability plan for the participant. The employability plan shall explain the services that will be provided by the State agency and the activities in which the participant will take part under the program, including child care and other supportive services, shall set forth an employment goal for the participant, and shall, to the maximum extent possible and consistent with this section, reflect the respective preferences of such participant. The plan must take into account the participant's supportive services needs, available program resources, and local employment opportunities. The employability plan shall not be considered a contract.

(2) Following the initial assessment and review and the development of the employability plan with respect to any participant in the program, the State agency may require the participant (or the adult caretaker in the family of which the participant is a member) to negotiate and enter into an agreement with the State agency that specifies such matters as the participant's obligations under the program, the duration of participation in the program, and the activities to be conducted and the services to be provided in the course of such participation. If the State agency exercises the option under the preceding sentence, the State agency must give the participant such assistance as he or she may require in reviewing and understanding the agreement.

(3) The State agency may assign a case manager to each participant and the participant's family. The case manager so assigned must be responsible for assisting the family to obtain any services which may be needed to assure effective participation in the program.

(c) PROVISION OF PROGRAM AND EMPLOYMENT INFORMATION.—(1) The State agency must ensure that all applicants for and recipients of aid to families with dependent children are encouraged, assisted, and required to fulfill their responsibilities to support their children by preparing for, accepting, and retaining such employment as they are capable of performing.

(2) The State agency must inform all applicants for and recipients of aid to families with dependent children of the education, employment, and training opportunities, and the support services (including child care and health coverage transition options), for which they are eligible, the obligations of the State agency, and the rights, responsibilities, and obligations of participants in the program.

(3) The State agency must—

(A) provide (directly or through arrangements with others) information on the types and locations of child care services reasonably accessible to participants in the program,

(B) inform participants that assistance is available to help them select appropriate child care services, and

(C) on request, provide assistance to participants in obtaining child care services.

(4) The State agency must inform applicants for and recipients of aid to families with dependent children of the grounds for exemption from participation in the program and the consequences of refusal to participate if not exempt, and provide other appropriate information with respect to such participation.

(5) Within one month after the State agency gives a recipient of aid to families with dependent children the information described in the preceding provisions of this paragraph, the State agency must notify such recipient of the opportunity to indicate his or her desire to participate in the program, including a clear description of how to enter the program.

(d) SERVICES AND ACTIVITIES UNDER THE PROGRAM.—(1)(A) In carrying out the program, each State shall make available a broad range of services and activities to aid in carrying out the purpose of this part. Such services and activities—

(i) shall include—

(I) educational activities (as appropriate), including high school or equivalent education (combined with training as needed), basic and remedial education to achieve a basic literacy level, and education for individuals with limited English proficiency;

(II) job skills training;

(III) job readiness activities to help prepare participants for work; and

(IV) job development and job placement; and

(ii) must also include at least 2 of the following:

(I) group and individual job search as described in subsection (g);

(II) on-the-job training;

(III) work supplementation programs as described in subsection (e); and

(IV) community work experience programs as described in subsection (f) or any other work experience program approved by the Secretary.

(B) The State may also offer to participants under the program (i) postsecondary education in appropriate cases, and (ii) such other education, training, and employment activities as may be determined by the State and allowed by regulations of the Secretary.

(2) If the State requires an individual who has attained the age of 20 years and has not earned a high school diploma (or equivalent) to participate in the program, the State agency shall include educational activities consistent with his or her employment goals as a component of the individual's participation in the program, unless the individual demonstrates a basic literacy level, or the employability plan for the individual identifies a long-term employment goal that does not require a high school diploma (or equivalent). Any other services or activities to which such a participant is assigned may not be permitted to interfere with his or her participation in an appropriate educational activity under this subparagraph.

(3) Notwithstanding any other provision of this section, the Secretary shall permit up to 5 States to provide services under the program, on a voluntary or mandatory basis, to non-custodial parents who are unemployed and unable to meet their child support obligations. Any State providing services to non-custodial parents pursuant to this paragraph shall evaluate the provision of such services, giving particular attention to the extent to which the provision of such services to those parents is contributing to the achievement of the purpose of this part, and shall report the results of such evaluation to the Secretary.

(e) WORK SUPPLEMENTATION PROGRAM.—(1) Any State may institute a work supplementation program under which such State, to the extent it considers appropriate, may reserve the sums that would otherwise be payable to participants in the program as aid to families with dependent children and use such sums instead for the purpose of providing and subsidizing jobs for such participants (as described in paragraph (3)(C)(i) and (ii)), as an alternative to the aid to families with dependent children that would otherwise be so payable to them.

(2)(A) Notwithstanding section 406 or any other provision of law, Federal funds may be paid to a State under part A, subject to this subsection, with respect to expenditures incurred in operating a work supplementation program under this subsection.

(B) Nothing in this part, or in any State plan approved under part A, shall be construed to prevent a State from operating (on such terms and conditions and in such cases as the State may find to be necessary or appropriate) a work supplementation program in accordance with this subsection and section 484.

(C) Notwithstanding section 402(a)(23) or any other provision of law, a State may adjust the levels of the standards of need under the State plan as the State determines to be necessary and appropriate for carrying out a work supplementation program under this subsection.

(D) Notwithstanding section 402(a)(1) or any other provision of law, a State operating a work supplementation program under this subsection may provide that the need standards in effect in those areas of the State in which such program is in operation may be different from the need standards in effect in the areas in which such program is not in operation, and such State may provide that the need standards for categories of recipients may vary among such categories to the extent the State determines to be appropriate on the basis of ability to participate in the work supplementation program.

(E) Notwithstanding any other provision of law, a State may make such further adjustments in the amounts of the aid to families with dependent children paid under the plan to different categories of recipients (as determined under subparagraph (D)) in order to offset increases in benefits from needs-related programs (other than the State plan approved under part A) as the State determines to be necessary and appropriate to further the purposes of the work supplementation program.

(F) In determining the amounts to be reserved and used for providing and subsidizing jobs under this subsection as described in paragraph (1), the State may use a sampling methodology.

(G) Notwithstanding section 402(a)(8) or any other provision of law, a State operating a work supplementation program under this subsection (i) may reduce or eliminate the amount of earned income to be disregarded under the State plan as the State determines to be necessary and appropriate to further the purposes of the work supplementation program, and (ii) during one or more of the first 9 months of an individual's employment pursuant to a program under this section, may apply to the wages of the individual the provisions of subparagraph (A)(iv) of section 402(a)(8) without regard to the provisions of subparagraph (B)(ii)(II) of such section.

(3)(A) A work supplementation program operated by a State under this subsection may provide that any individual who is an eligible individual (as determined under subparagraph (B)) shall take a supplemented job (as defined in subparagraph (C)) to the extent that supplemented jobs are available under the program. Payments by the State to individuals or to employers under the work supplementation program shall be treated as expenditures incurred by the State for aid to families with dependent children except as limited by paragraph (4).

(B) For purposes of this subsection, an eligible individual is an individual who is in a category which the State determines should be eligible to participate in the work supplementation program, and who would, at the time of placement in the job involved, be eligible for aid to families with dependent children under an approved State plan if such State did not have a work supplementation program in effect.

(C) For purposes of this section, a supplemented job is—

(i) a job provided to an eligible individual by the State or local agency administering the State plan under part A; or

(ii) a job provided to an eligible individual by any other employer for which all or part of the wages are paid by such State or local agency.

A State may provide or subsidize under the program any job which such State determines to be appropriate.

(D) At the option of the State, individuals who hold supplemented jobs under a State's work supplementation program shall be exempt from the retrospective budgeting requirements imposed pursuant to section 402(a)(13)(A)(ii) (and the amount of the aid which is payable to the family of any such individual for any month, or which would be so payable but for the individual's participation in the work supplementation program, shall be determined on the basis of the income and other relevant circumstances in that month).

(4) The amount of the Federal payment to a State under section 403 for expenditures incurred in making payments to individuals and employers under a work supplementation program under this subsection shall not exceed an amount equal to the amount which would otherwise be payable under such section if the family of each individual employed in the program established in such State under this subsection had received the maximum amount of aid to families with dependent children payable under the State plan to such a family with no income (without regard to adjustments under paragraph (2)) for the lesser of (A) 9 months, or (B) the number of months in which such individual was employed in such program.

(5)(A) Nothing in this subsection shall be construed as requiring the State or local agency administering the State plan to provide employee status to an eligible individual to whom it provides a job under the work supplementation program (or with respect to whom it provides all or part of the wages paid to the individual by another entity under such program), or as requiring any State or local agency to provide that an eligible individual filling a job position provided by another entity under such program be provided employee status by such entity during the first 13 weeks such individual fills that position.

(B) Wages paid under a work supplementation program shall be considered to be earned income for purposes of any provision of law.

(6) Any State that chooses to operate a work supplementation program under this subsection shall provide that any individual who participates in such program, and any child or relative of such individual (or other individual living in the same household as such individual) who would be eligible for aid to families with dependent children under the State plan approved under part A if such State did not have a work supplementation program, shall be considered individuals receiving aid to families with dependent children under the State plan approved under part A for purposes of eligibility for medical assistance under the State plan approved under title XIX.

(7) No individual receiving aid to families with dependent children under a State plan shall be excused by reason of the fact that such

State has a work supplementation program from any requirement of this part relating to work requirements, except during periods in which such individual is employed under such work supplementation program.

(f) COMMUNITY WORK EXPERIENCE PROGRAM.—(1)(A) Any State may establish a community work experience program in accordance with this subsection. The purpose of the community work experience program is to provide experience and training for individuals not otherwise able to obtain employment, in order to assist them to move into regular employment. Community work experience programs shall be designed to improve the employability of participants through actual work experience and training and to enable individuals employed under community work experience programs to move promptly into regular public or private employment. The facilities of the State public employment offices may be utilized to find employment opportunities for recipients under this program. Community work experience programs shall be limited to projects which serve a useful public purpose in fields such as health, social service, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public facilities, public safety, and day care. To the extent possible, the prior training, experience, and skills of a recipient shall be used in making appropriate work experience assignments.

(B)(i) A State that elects to establish a community work experience program under this subsection shall operate such program so that each participant (as determined by the State) either works or undergoes training (or both) with the maximum number of hours that any such individual may be required to work in any month being a number equal to the amount of the aid to families with dependent children payable with respect to the family of which such individual is a member under the State plan approved under this part, divided by the greater of the Federal minimum wage or the applicable State minimum wage (and the portion of a recipient's aid for which the State is reimbursed by a child support collection shall not be taken into account in determining the number of hours that such individual may be required to work).

(ii) After an individual has been assigned to a position in a community work experience program under this subsection for 9 months, such individual may not be required to continue in that assignment unless the maximum number of hours of participation is no greater than (I) the amount of the aid to families with dependent children payable with respect to the family of which such individual is a member under the State plan approved under this part (excluding any portion of such aid for which the State is reimbursed by a child support payment), divided by (II) the higher of (a) the Federal minimum wage or the applicable State minimum wage, whichever is greater, or (b) the rate of pay for individuals employed in the same or similar occupations by the same employer at the same site.

(C) Nothing contained in this subsection shall be construed as authorizing the payment of aid to families with dependent children as compensation for work performed, nor shall a participant be entitled to a salary or to any other work or training expense provided under any other provision of law by reason of his participation in a program under this subsection.

(D) Nothing in this part or in any State plan approved under this part shall be construed to prevent a State from operating (on such terms and conditions and in such cases as the State may find to be necessary or appropriate) a community work experience program in accordance with this subsection and subsection (d).

(E) Participants in community work experience programs under this subsection may perform work in the public interest (which otherwise meets the requirements of this subsection) for a Federal office or agency with its consent, and, notwithstanding section 1342 of title 31, United States Code, or any other provision of law, such agency may accept such services, but such participants shall not be considered to be Federal employees for any purpose.

(2) After each 6 months of an individual's participation in a community work experience program under this subsection, and at the conclusion of each assignment of the individual under such program, the State agency must provide a reassessment and revision, as appropriate, of the individual's employability plan.

(3) The State agency shall provide coordination among a community work experience program operated pursuant to this subsection, any program of job search under subsection (g), and the other employment-related activities under the program established by this section so as to insure that job placement will have priority over participation in the community work experience program, and that individuals eligible to participate in more than one such program are not denied aid to families with dependent children on the grounds of failure to participate in one such program if they are actively and satisfactorily participating in another. The State agency may provide that part-time participation in more than one such program may be required where appropriate.

(4) In the case of any State that makes expenditures in the form described in paragraph (1) under its State plan approved under section 482(a)(1), expenditures for the operation and administration of the program under this section may not include, for purposes of section 403, the cost of making or acquiring materials or equipment in connection with the work performed under a program referred to in paragraph (1) or the cost of supervision of work under such program, and may include only such other costs attributable to such programs as are permitted by the Secretary.

(g) JOB SEARCH PROGRAM.—(1) The State agency may establish and carry out a program of job search for individuals participating in the program under this part.

(2) Notwithstanding section 402(a)(19)(B)(i), the State agency may require job search by an individual applying for or receiving aid to families with dependent children (other than an individual described in section 402(a)(19)(C) who is not an individual with respect to whom section 402(a)(19)(D) applies)—

(A) subject to the next to last sentence of this paragraph, beginning at the time such individual applies for aid to families with dependent children and continuing for a period (prescribed by the State) of not more than 8 weeks (but this requirement may not be used as a reason for any delay in making a determination of an individual's eligibility for such aid or in issuing a payment to or on behalf of any individual who is otherwise eligible for such aid); and

(B) at such time or times after the close of the period prescribed under subparagraph (A) as the State agency may determine but not to exceed a total of 8 weeks in any period of 12 consecutive months.

In no event may an individual be required to participate in job search for more than 3 weeks before the State agency conducts the assessment and review with respect to such individual under subsection (b)(1)(A). Job search activities in addition to those required under the preceding provisions of this paragraph may be required only in combination with some other education, training, or employment activity which is designed to improve the individual's prospects for employment.

(3) Job search by an individual under this subsection shall in no event be treated, for any purpose, as an activity under the program if the individual has participated in such job search for 4 months out of the preceding 12 months.

(h) DISPUTE RESOLUTION PROCEDURES.—Each State shall establish a conciliation procedure for the resolution of disputes involving an individual's participation in the program and (if the dispute involved is not resolved through conciliation) shall provide an opportunity for a hearing with respect to the dispute, which hearing may be provided through a hearing process established for purposes of resolving disputes with respect to the program or through the provision of a hearing pursuant to section 402(a)(4); but in no event shall aid to families with dependent children be suspended, reduced, discontinued, or terminated as a result of a dispute involving an individual's participation in the program until such individual has an opportunity for a hearing that meets the standards set forth by the United States Supreme Court in Goldberg v. Kelly, 397 U.S. 254 (1970).

(i) SPECIAL PROVISIONS RELATING TO INDIAN TRIBES.—(1) Within 6 months after the date of the enactment of the Family Support Act of 1988[251], an Indian tribe or Alaska Native organization may apply to the Secretary to conduct a job opportunities and basic skills training program to carry out the purpose of this subsection. If the Secretary approves such tribe's or organization's application, the maximum amount that may be paid to the State under section 403(l) in which such tribe or organization is located shall be reduced by the Secretary in accordance with paragraph (2) and an amount equal to the amount of such reduction shall be paid directly to such tribe or organization (without the requirement of any nonfederal share) for the operation of such program. In determining whether to approve an application from an Alaska Native organization, the Secretary shall consider whether approval of the application would promote the efficient and nonduplicative administration of job opportunities and basic skills training programs in the State.

(2) The amount of the reduction under paragraph (1) with respect to any State in which is located an Indian tribe or Alaska Native organization with an application approved under such paragraph shall be an amount equal to the amount that bears the same ratio to the maximum amount that could be paid under section 403(l) to the State as—

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[251] P.L. 100-485, enacted October 13, 1988.

(A) the number of adult members of such Indian tribe receiving aid to families with dependent children bears to the number of all such adult recipients in the State, or

(B) the number of adult Alaska Natives receiving aid to families with dependent children who reside within the boundaries of such Alaska Native organization bears to the number of all such adult recipients in the State of Alaska.

(3) The job opportunities and basic skills training program set forth in the application of an Indian tribe or Alaska Native organization under paragraph (1) need not meet any requirement of the program under this part or under section 402(a)(19) that the Secretary determines is inappropriate with respect to such job opportunities and basic skills training program.

(4) The job opportunities and basic skills training program of any Indian tribe or Alaska Native organization may be terminated voluntarily by such tribe or Alaska Native organization or may be terminated by the Secretary upon a finding that the tribe or Alaska Native organization is not conducting such program in substantial conformity with the terms of the application approved by the Secretary, and the maximum amount that may be paid under section 403(l) to the State within which the tribe or Alaska Native organization is located (as reduced pursuant to paragraph (1)) shall be increased by any portion of the amount retained by the Secretary with respect to such program (and not payable to such tribe or Alaska Native organization for obligations already incurred). The reduction under paragraph (1) shall in no event apply to a State for any fiscal year beginning after such program is terminated if no other such program remains in operation in the State.

(5) For purposes of this subsection, an Indian tribe is any tribe, band, nation, or other organized group or community of Indians that—

(A) is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians; and

(B) for which a reservation (as defined in paragraph (6)) exists.

(6) For purposes of this subsection, a reservation includes Indian reservations, public domain Indian allotments, and former Indian reservations in Oklahoma.

(7) For purposes of this subsection—

(A) an Alaska Native organization is any organized group of Alaska Natives eligible to operate a Federal program under Public Law 93-638 or such group's designee;

(B) the boundaries of an Alaska Native organization shall be those of the geographical region, established pursuant to section 7(a) of the Alaska Native Claims Settlement Act, within which the Alaska Native organization is located (without regard to the ownership of the land within the boundaries);

(C) the Secretary may approve only one application from an Alaska Native organization for each of the 12 geographical regions established pursuant to section 7(a) of the Alaska Native Claims Settlement Act; and

(D) any Alaska Native, otherwise eligible or required to participate in a job opportunities and basic skills training program, residing within the boundaries of an Alaska Native organization whose application has been approved by the Secretary, shall be eligible to participate in the job opportunities and basic skills training program administered by such Alaska Native organization.

(8) Nothing in this subsection shall be construed to grant or defer any status or powers other than those expressly granted in this subsection or to validate or invalidate any claim by Alaska Natives of sovereign authority over lands or people.[252]

COORDINATION REQUIREMENTS

SEC. 483. [42 U.S.C. 683] (a)(1) The Governor of each State shall assure that program activities under this part are coordinated in that State with programs operated under the Job Training Partnership Act[253] and with any other relevant employment, training, and education programs available in that State. Appropriate components of the State's plan developed under section 482(a)(1) which relate to job training and work preparation shall be consistent with the coordination criteria specified in the Governor's coordination and special services plan required under section 121 of the Job Training Partnership Act.

(2) The State plan so developed shall be submitted to the State job training coordinating council not less than 60 days before its submission to the Secretary, for the purpose of review and comment by the council. Concurrent with submission of the plan to the State job training coordinating council, the proposed State plan shall be published and made reasonably available to the general public through local news facilities and public announcements, in order to provide the opportunity for review and comment.

(3) The comments and recommendations of the State job training coordinating council under paragraph (2) shall be transmitted to the Governor of the State.

(b) The Secretary of Health and Human Services shall consult with the Secretaries of Education and Labor on a continuing basis for the purpose of assuring the maximum coordination of education and training services in the development and implementation of the program under this part.

(c) The State agency responsible for administering or supervising the administration of the State plan approved under part A shall consult with the State education agency and the agency responsible for administering job training programs in the State in order to promote coordination of the planning and delivery of services under the program with programs operated under the Job Training Partnership Act and with education programs available in the State (including any program under the Adult Education Act[254] or Carl D. Perkins Vocational Education Act[255]).

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[252] See Vol. II, P.L. 101-508, §5064, with respect to a study of jobs programs operated by Indian tribes and Alaska Native organizations.

[253] See Vol. II, P.L. 97-300.

[254] See Vol. II, P.L. 89-750, Title III.

[255] See Vol. II, P.L. 88-210.

PROVISIONS GENERALLY APPLICABLE TO PROVISION OF SERVICES

SEC. 484. [42 U.S.C. 684] (a) In assigning participants in the program under this part to any program activity, the State agency shall assure that—

(1) each assignment takes into account the physical capacity, skills, experience, health and safety, family responsibilities, and place of residence of the participant;

(2) no participant will be required, without his or her consent, to travel an unreasonable distance from his or her home or remain away from such home overnight;

(3) individuals are not discriminated against on the basis of race, sex, national origin, religion, age, or handicapping condition, and all participants will have such rights as are available under any applicable Federal, State, or local law prohibiting discrimination;

(4) the conditions of participation are reasonable, taking into account in each case the proficiency of the participant and the child care and other supportive services needs of the participant; and

(5) each assignment is based on available resources, the participant's circumstances, and local employment opportunities.

(b) Appropriate workers' compensation and tort claims protection must be provided to participants on the same basis as they are provided to other individuals in the State in similar employment (as determined under regulations of the Secretary).

(c) No work assignment under the program shall result in—

(1) the displacement of any currently employed worker or position (including partial displacement such as a reduction in the hours of nonovertime work, wages, or employment benefits), or result in the impairment of existing contracts for services or collective bargaining agreements;

(2) the employment or assignment of a participant or the filling of a position when (A) any other individual is on layoff from the same or any equivalent position, or (B) the employer has terminated the employment of any regular employee or otherwise reduced its workforce with the effect of filling the vacancy so created with a participant subsidized under the program; or

(3) any infringement of the promotional opportunities of any currently employed individual.

Funds available to carry out the program under this part may not be used to assist, promote, or deter union organizing. No participant may be assigned under section 482(e) or (f) to fill any established unfilled position vacancy.

(d)(1) The State shall establish and maintain (pursuant to regulations jointly issued by the Secretary and the Secretary of Labor) a grievance procedure for resolving complaints by regular employees or their representatives that the work assignment of an individual under the program violates any of the prohibitions described in subsection (c). A decision of the State under such procedure may be appealed to the Secretary of Labor for investigation and such action as such Secretary may find necessary.

(2) The State shall hear complaints with respect to working conditions and workers' compensation, and wage rates in the case of

individuals participating in community work experience programs described in section 482(f), under the State's fair hearing process. A decision of the State under such process may be appealed to the Secretary of Labor under such conditions as the joint regulations issued under subsection (f) may provide.

(e) The provisions of this section apply to any work-related programs and activities under this part, and under any other work-related programs and activities authorized (in connection with the AFDC program) under section 1115.

(f) The Secretary of Health and Human Services and the Secretary of Labor shall jointly prescribe and issue regulations for the purpose of implementing and carrying out the provisions of this section, in accordance with the timetable established in section 203(a) of the Family Support Act of 1988[256].

CONTRACT AUTHORITY

SEC. 485. [42 U.S.C. 685] (a) The State agency that administers or supervises the administration of the State's plan approved under section 402 shall carry out the programs under this part directly or through arrangements or under contracts with administrative entities under section 4(2) of the Job Training Partnership Act[257], with State and local educational agencies, and with other public agencies or private organizations (including community-based organizations as defined in section 4(5) of such Act).

(b) Arrangements and contracts entered into under subsection (a) may cover any service or activity (including outreach) to be made available under the program to the extent that the service or activity is not otherwise available on a nonreimbursable basis.

(c) The State agency and private industry councils (as established under section 102 of the Job Training Partnership Act) shall consult on the development of arrangements and contracts under the program established under a plan approved under section 482(a)(1), and under programs established under such Act.

(d) In selecting service providers, the State agency shall take into account appropriate factors which may include past performance in providing similar services, demonstrated effectiveness, fiscal accountability, ability to meet performance standards, and such other factors as the State may determine to be appropriate.

(e) The State agency shall use the services of each private industry council to identify and provide advice on the types of jobs available or likely to become available in the service delivery area (as defined in the Job Training Partnership Act) of the council, and shall ensure that the State program provides training in any area for jobs of a type which are, or are likely to become, available in the area.

INITIAL STATE EVALUATIONS

SEC. 486. [42 U.S.C. 686] (a) With the objective of—

(1) providing an in-depth assessment of potential participants in the program under this part in each State, so as to furnish an accurate picture on which to base estimates of future demands

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[256] P.L. 100-485.

[257] P.L. 97-300.

for services in conducting such program and to improve the efficiency of targeting under such program,

(2) assuring that training for recipients of aid under such program will be realistically geared to labor market demands and that the program will produce individuals with marketable skills, while avoiding duplication and redundancy in the delivery of services, and

(3) otherwise assuring that States will have the information needed to carry out the purposes of the program,

each State may undertake and carry out an evaluation of demographic characteristics of potential participants in the program under this part within the 12-month period beginning on the date of the enactment of the Family Support Act of 1988[258]. Such evaluation shall be carried out in each State by the agency which administers the State's program approved under section 402.

(b) In carrying out the evaluation under subsection (a) the State shall give particular attention to the current and anticipated demands of the labor market or markets within the State, the types of training which are needed to meet those demands, and any changes in the current service delivery systems which may be needed to satisfy the requirements of the program under this part.

(c) The evaluation shall be structured so as to produce accurate and usable information on the age, family status, educational and literacy levels, duration of eligibility for aid to families with dependent children, and work experience of the individuals and families who are potential participants in the program under this part, including the actual numbers of such individuals and families in each such category.

(d) The Secretary of Health and Human Services, in consultation with the Secretary of Labor, shall provide each State with such technical assistance and data as it may need in order to carry out its evaluation under subsection (a); and each State shall transmit its evaluation to the Secretary by the close of the 12-month period specified in such subsection. The Secretary of Health and Human Services shall take such evaluations into account in developing performance standards.

(e) As used in this section, the term "potential participants" with respect to any State's program under this part means collectively all individuals in such State who are recipients of aid to families with dependent children under part A and who are members of the target populations identified in section 403(l)(2).

PERFORMANCE STANDARDS[259]

SEC. 487. **[42 U.S.C. 687]** (a) Not later than 3 years after the effective date specified in section 204(a) of the Family Support Act of 1988[260], the Secretary shall—

(1) in consultation with the Secretary of Labor, representatives of organizations representing Governors, State and local program administrators, educators, State job training coordinating councils, community-based organizations, recipients, and other

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[258] P.L. 100-485, enacted October 13, 1988.

[259] P.L. 100-485, §203(b), added §487. For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

[260] P.L. 100-485, §204(a), specified "October 1, 1990".

interested persons, develop performance standards with respect to the programs established pursuant to this part that are based, in part, on the results of the studies conducted under section 203(c) of such Act, and the initial State evaluations (if any) performed under section 486 of this Act; and

(2) submit his recommendations for performance standards developed under paragraph (1) to the appropriate committees of jurisdiction of the Congress, which recommendations shall be made with respect to specific measurements of outcomes and be based on the degree of success which may reasonably be expected of States in helping individuals to increase earnings, achieve self-sufficiency, and reduce welfare dependency, and shall not be measured solely by levels of activity or participation.

Performance standards developed under this subsection shall be reviewed periodically by the Secretary and modified to the extent necessary.

(b) The Secretary may collect information from the States to assist in the development of performance standards under subsection (a), and shall include in his regulations (issued pursuant to section 203(a) of the Family Support Act of 1988 with respect to the program under this part) provisions establishing uniform reporting requirements under which States must furnish periodically information and data, including information and data (for each program activity) on the average monthly number of families assisted, the types of such families, the amounts spent per family, the length of their participation, and such other matters as the Secretary may determine.

(c) The Secretary shall develop and transmit to the Congress, for appropriate legislative action, a proposal for measuring State progress, providing technical assistance to enable States to meet performance standards, and modifying the Federal matching rate to reflect the relative effectiveness of the various States in carrying out the program.

TITLE V—MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT[1]

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AUTHORIZATION OF APPROPRIATIONS

SEC. 501. [42 U.S.C. 701] (a) To improve the health of all mothers and children consistent with the applicable health status goals and national health objectives established by the Secretary under the Public Health Service Act for the year 2000, there are authorized to be appropriated $686,000,000 for fiscal year 1990 and each fiscal year thereafter—

(1) for the purpose of enabling each State—

(A) to provide and to assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services;

(B) to reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women, and to promote the health of children by providing preventive and primary care services for low income children;

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[1] Title V of the Social Security Act is administered by the Health Resources and Services Administration, Public Health Service, Department of Health and Human Services.

Title V appears in the United States Code as §§701-709, subchapter V, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services relating to Title V are contained in chapter I, Title 42, and in subtitle A, Title 45, Code of Federal Regulations.

See Vol. II, P.L. 78-410, § 317A(a) and (d), with respect to coordination required in lead poisoning prevention.

See Vol. II, P.L. 88-352, § 601, with respect to prohibition against discrimination in federally assisted programs.

See Vol. II, P.L. 95-21, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 101-239, §6506, with respect to development of model applications for maternal and child assistance programs; §6508, with respect to a demonstration project on health insurance for medically uninsurable children; and §6509, with respect to a maternal and child health handbook.

[2] This table of contents does not appear in the law.

(C) to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI, to the extent medical assistance for such services is not provided under title XIX; and

(D) to provide and to promote family-centered, community-based, coordinated care (including care coordination services, as defined in subsection (b)(3)) for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families;

(2) for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for special projects of regional and national significance, research, and training with respect to maternal and child health and children with special health care needs (including early intervention training and services development), for genetic disease testing, counseling, and information development and dissemination programs, for grants (including funding for comprehensive hemophilia diagnostic treatment centers) relating to hemophilia without regard to age, and for the screening of newborns for sickle cell anemia, and other genetic disorders and follow-up services; and

(3) subject to section 502(b) for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for developing and expanding the following—

(A) maternal and infant health home visiting programs in which case management services as defined in subparagraphs (A) and (B) of subsection (b)(4), health education services, and related social support services are provided in the home to pregnant women or families with an infant up to the age one by an appropriate health professional or by a qualified nonprofessional acting under the supervision of a health care professional,

(B) projects designed to increase the participation of obstetricians and pediatricians under the program under this title and under state plans approved under title XIX,

(C) integrated maternal and child health service delivery systems (of the type described in section 1136 and using, once developed, the model application form developed under section 6506(a) of the Omnibus Budget Reconciliation Act of 1989),

(D) maternal and child health centers which (i) provide prenatal, delivery, and postpartum care for pregnant women and preventive and primary care services for infants up to age one, and (ii) operate under the direction of a not-for-profit hospital,

(E) maternal and child health projects to serve rural populations, and

(F) outpatient and community based services programs (including day care services) for children with special health care needs whose medical services are provided primarily through inpatient institutional care.[3]

(b) For purposes of this title:

(1) The term "consolidated health programs" means the programs administered under the provisions of—

(A) this title (relating to maternal and child health and services for children with special health care needs),

(B) section 1615(c) of this Act (relating to supplemental security income for disabled children),

(C) sections 316 (relating to lead-based paint poisoning prevention programs), 1101 (relating to genetic disease programs), 1121 (relating to sudden infant death syndrome programs) and 1131 (relating to hemophilia treatment centers) of the Public Health Service Act[4], and

(D) title VI[5] of the Health Services and Centers Amendments of 1978 (Public Law 95-626; relating to adolescent pregnancy grants),

as such provisions were in effect before the date of the enactment of the Maternal and Child Health Services Block Grant Act[6].

(2) The term "low income" means, with respect to an individual or family, such an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981[7].

(3) The term "care coordination services" means services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families.[8]

(4) The term "case management services" means—

(A) with respect to pregnant women, services to assure access to quality prenatal, delivery, and postpartum care; and

(B) with respect to infants up to age one, services to assure access to quality preventive and primary care services.[9]

ALLOTMENTS TO STATES AND FEDERAL SET-ASIDE

SEC. 502. [42 U.S.C. 702] (a)(1) Of the amounts appropriated under section 501(a) for a fiscal year that are not in excess of $600,000,000, the Secretary shall retain an amount equal to 15 percent for the purpose of carrying out activities described in section 501(a)(2).[10] The authority of the Secretary to enter into any contracts under this title is effective for any fiscal year only to such extent or in such amounts as are provided in appropriations Acts.

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[3] P.L. 101-239, §6501(a)(1), amended subsection (a) in its entirety, applicable to appropriations for fiscal years beginning with fiscal year 1990. [For subsection (a) as it formerly read, see Vol. III, P.L. 101-239.]

[4] P.L. 78-410. P.L. 97-35, §2193(b)(1), 95 Stat. 827, repealed §§316, 1101, 1121, and 1131 of the PHSA.

[5] P.L. 95-626, Title VI, was repealed by P.L. 97-35, §955(b); 95 Stat. 592.

[6] P.L. 97-35, Title XXI, subtitle D [95 Stat. 818].

[7] P.L. 97-35.

[8] P.L. 101-239, §6501(a)(2), added paragraph (3), applicable to appropriations for fiscal years beginning with fiscal year 1990.

[9] P.L. 101-239, §6501(a)(2), added paragraph (4), applicable to appropriations for fiscal years beginning with fiscal year 1990.

(2) For purposes of paragraph (1)—

(A) amounts retained by the Secretary for training shall be used to make grants to public or nonprofit private institutions of higher learning for training personnel for health care and related services for mothers and children; and

(B) amounts retained by the Secretary for research shall be used to make grants to, contracts with, or jointly financed cooperative agreements with, public or nonprofit institutions of higher learning and public or nonprofit private agencies and organizations engaged in research or in maternal and child health or programs for children with special health care needs for research projects relating to maternal and child health services or services for children with special health care needs which show promise of substantial contribution to the advancement thereof.

(3) No funds may be made available by the Secretary under this subsection or subsection (b)[11] unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner, and contain and be accompanied by such information as the Secretary may specify. No such application may be approved unless it contains assurances that the applicant will use the funds provided only for the purposes specified in the approved application and will establish such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting of Federal funds paid to the applicant under this title.

(b)(1)(A) Of the amounts appropriated under section 501(a) for a fiscal year in excess of $600,000,000 the Secretary shall retain an amount equal to 12 3/4 percent thereof for the projects described in subparagraphs (A) through (F) of section 501(a)(3).

(B) Any amount appropriated under section 501(a) for a fiscal year in excess of $600,000,000 that remains after the Secretary has retained the applicable amount (if any) under subparagraph (A) shall be retained by the Secretary in accordance with subsection (a) and allocated to the States in accordance with subsection (c).

(2)(A) Of the amounts retained for the purpose of carrying out activities described in section 501(a)(3)(A), (B), (C), (D) and (E), the Secretary shall provide preference to qualified applicants which demonstrate that the activities to be carried out with such amounts shall be in areas with a high infant mortality rate (relative to the average infant mortality rate in the United States or in the State in which the area is located).

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[10] P.L. 101-239, §6502(a)(1), struck out "$478,000,000, the Secretary shall retain an amount equal to 15 percent thereof in the case of fiscal year 1982, and an amount equal to not less than 10, nor more than 15, percent thereof in the case of each fiscal year thereafter, for the purpose of carrying out (through grants, contracts, or otherwise) special projects of regional and national significance, training, and research and for the funding of genetic disease testing, counseling, and information development and dissemination programs and of comprehensive hemophilia diagnostic and treatment centers.", and substituted "$600,000,000, the Secretary shall retain an amount equal to 15 percent for the purpose of carrying out activities described in section 501(a)(2).", applicable to appropriations for fiscal years beginning with fiscal year 1990.

[11] P.L. 101-239, §6502(a)(2), inserted "or subsection (b)", applicable to appropriations for fiscal years beginning with fiscal year 1990.

(B) In carrying out activities described in section 501(a)(3)(D), the Secretary shall not provide for developing or expanding a maternal and child health center unless the Secretary has received satisfactory assurances that there will be applied, towards the costs of such development or expansion, non-Federal funds in an amount at least equal to the amount of funds provided under this title toward such development or expansion.[12]

(c)[13] From the remaining amounts appropriated under section 501(a) for any fiscal year that are not in excess of $600,000,000[14], the Secretary shall allot to each State which has transmitted an application[15] for the fiscal year under section 505(a)[16], an amount determined as follows:

(1) The Secretary shall determine, for each State—

(A)(i) the amount provided or allotted by the Secretary to the State and to entities in the State under the provisions of the consolidated health programs (as defined in section 501(b)(1)), other than for any of the projects or programs described in subsection (a), from appropriations for fiscal year 1981,

(ii) the proportion that such amount for that State bears to the total of such amounts for all the States, and

(B)(i) the number of low income children in the State, and

(ii) the proportion that such number of children for that State bears to the total of such numbers of children for all the States.

(2) Each such State shall be allotted for each fiscal year an amount equal to the sum of—

(A) the amount of the allotment to the State under this subsection in fiscal year 1983, and

(B) the State's proportion (determined under paragraph (1)(B)(ii)) of the amount by which the allotment available under this subsection for all the States for that fiscal year exceeds the amount that was available under this subsection for allotment for all the States for fiscal year 1983.[17]

(d)(1) To the extent that all the funds appropriated under this title for a fiscal year are not otherwise allotted to States either because all the States have not qualified for such allotments under section 505(a)[18] for the fiscal year or because some States have indicated in their descriptions of activities under section 505(a)[19] that they do not intend to use the full amount of such allotments, such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this paragraph.

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[12] P.L. 101-239, §6502(a)(3), inserted this subsection (b), applicable to appropriations for fiscal years beginning with fiscal year 1990.

[13] P.L. 101-239, §6502(a)(3), struck out subsection (c) and redesignated subsection (b) as subsection (c). [For subsection (c) as it formerly read, see Vol. III, P.L. 101-239.]

[14] P.L. 101-239, §6502(a)(4)(A), struck out "$478,000,000", and substituted "$600,000,000", applicable to appropriations for fiscal years beginning with fiscal year 1990.

[15] P.L. 101-239, §6503(c)(1), struck out "a description of intended activities and statement of assurances" and substituted "an application", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[16] P.L. 101-239, §6503(c)(4), inserted "(a)", applicable to payments for allotments for fiscal years beginning with fiscal year 1991. Executed as if P.L. 101-239, §6503(c)(4), reads "Sections 502(c) . . .".

[17] P.L. 101-239, §6502(a)(4)(B), amended paragraph (2) in its entirety, applicable to appropriations for fiscal years beginning with fiscal year 1990. [For paragraph (2) as it formerly read, see Vol. III, P.L. 101-239.]

[18] P.L. 101-239, §6503(c)(4), inserted "(a)", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[19] P.L. 101-239, §6503(c)(4), inserted "(a)", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

(2) To the extent that all the funds appropriated under this title for a fiscal year are not otherwise allotted to States because some State allotments are offset under section 506(b)(2), such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this paragraph.

PAYMENTS TO STATES

SEC. 503. [42 U.S.C. 703] (a) From the sums appropriated therefor and the allotments available under section 502(c)[20], the Secretary shall make payments as provided by section 6503(a) of title 31, United States Code to each State provided such an allotment under section 502(c)[21], for each quarter, of an amount equal to four-sevenths of the total of the sums expended by the State during such quarter in carrying out the provisions of this title.

(b) Any amount payable to a State under this title from allotments for a fiscal year which remains unobligated at the end of such year shall remain available to such State for obligation during the next fiscal year. No payment may be made to a State under this title from allotments for a fiscal year for expenditures made after the following fiscal year.

(c) The Secretary, at the request of a State, may reduce the amount of payments under subsection (a) by—

(1) the fair market value of any supplies or equipment furnished the State, and

(2) the amount of the pay, allowances, and travel expenses of any officer or employee of the Government when detailed to the State and the amount of any other costs incurred in connection with the detail of such officer or employee,

when the furnishing of supplies or equipment or the detail of an officer or employee is for the convenience of and at the request of the State and for the purpose of conducting activities described in section 505(a)[22] on a temporary basis. The amount by which any payment is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment or in detailing the personnel, on which the reduction of the payment is based, and the amount shall be deemed to be part of the payment and shall be deemed to have been paid to the State.

USE OF ALLOTMENT FUNDS

SEC. 504. [42 U.S.C. 704] (a) Except as otherwise provided under this section, a State may use amounts paid to it under section 503 for the provision of health services and related activities (including planning, administration, education, and evaluation and including payment of salaries and other related expenses of National Health

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[20] P.L. 101-239, §6502(b), struck out "502(b)", and substituted "502(c)", applicable to appropriations for fiscal years beginning with fiscal year 1990.

[21] P.L. 101-239, §6502(b), struck out "502(b)", and substituted "502(c)", applicable to appropriations for fiscal years beginning with fiscal year 1990.

[22] P.L. 101-239, §6503(c)(4), inserted "(a)", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

Service Corps personnel[23]) consistent with its application[24] transmitted under section 505(a)[25].

(b) Amounts described in subsection (a) may not be used for—

(1) inpatient services, other than inpatient services provided to children with special health care needs or to high-risk pregnant women and infants and such other inpatient services as the Secretary may approve;

(2) cash payments to intended recipients of health services;

(3) the purchase or improvement of land, the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility, or the purchase of major medical equipment;

(4) satisfying any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;

(5) providing funds for research or training to any entity other than a public or nonprofit private entity; or

(6) payment for any item or service (other than an emergency item or service) furnished—

(A) by an individual or entity during the period when such individual or entity is excluded under this title or title XVIII, XIX, or XX pursuant to section 1128, 1128A, 1156, or 1842(j)(2), or

(B) at the medical direction or on the prescription of a physician during the period when the physician is excluded under this title or title XVIII, XIX, or XX pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

The Secretary may waive the limitation contained in paragraph (3) upon the request of a State if the Secretary finds that there are extraordinary circumstances to justify the waiver and that granting the waiver will assist in carrying out this title.

(c) A State may use a portion of the amounts described in subsection (a) for the purpose of purchasing technical assistance from public or private entities if the State determines that such assistance is required in developing, implementing, and administering programs funded under this title.

(d) Of the amounts paid to a State under section 503 from an allotment for a fiscal year under section 502(c), not more than 10 percent may be used for administering the funds paid under such section.[26]

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[23] P.L. 101-239, §6503(a)(1), inserted "and including payment of salaries and other related expenses of National Health Service Corps personnel", applicable to appropriations for fiscal years beginning with fiscal year 1990.

[24] P.L. 101-239, §6503(c)(2), struck out "description of intended expenditures and statement of assurances", and substituted "application", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[25] P.L. 101-239, §6503(c)(4), inserted "(a)", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[26] P.L. 101-239, §6503(a)(2), added subsection (d), applicable to appropriations for fiscal years beginning with fiscal year 1990.

APPLICATION FOR BLOCK GRANT FUNDS[27]

SEC. 505. [42 U.S.C. 705] (a)[28] In order to be entitled to payments for allotments under section 502 for a fiscal year, a State must prepare and transmit to the Secretary an application (in a standardized form specified by the Secretary) that[29] —

(1) contains a statewide needs assessment (to be conducted every 5 years) that shall identify (consistent with the health status goals and national health objectives referred to in section 501(a)) the need for—

(A) preventive and primary care services for pregnant women, mothers, and infants up to age one;

(B) preventive and primary care services for children; and

(C) services for children with special health care needs (as specified in section 501(a)(1)(D));[30]

(2) includes for each fiscal year—

(A) a plan for meeting the needs identified by the statewide needs assessment under paragraph (1); and

(B) a description of how the funds allotted to the State under section 502(c) will be used for the provision and coordination of services to carry out such plan that shall include—

(i) subject to paragraph (3), a statement of the goals and objectives consistent with the health status goals and national health objectives referred to in section 501(a) for meeting the needs specified in the State plan described in subparagraph (A);

(ii) an identification of the areas and localities in the State in which services are to be provided and coordinated;

(iii) an identification of the types of services to be provided and the categories or characteristics of individuals to be served; and

(iv) information the State will collect in order to prepare reports required under section 506(a);[31]

(3) except as provided under subsection (b), provides that the State will use—

(A) at least 30 percent of such payment amounts for preventive and primary care services for children, and

(B) at least 30 percent of such payment amounts for services for children with special health care needs (as specified in section 501(a)(1)(D));[32]

(4) provides that a State receiving funds for maternal and child health services under this title shall maintain the level of funds

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[27] P.L. 101-239, §6503(b)(1), struck out "DESCRIPTION OF INTENDED EXPENDITURES AND STATEMENT OF ASSURANCES" and substituted "APPLICATION FOR BLOCK GRANT FUNDS", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[28] P.L. 101-239, §6503(b)(2), inserted "(a)".

[29] P.L. 101-239, §6503(b)(3), inserted "an application (in a standardized form specified by the Secretary) that", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[30] P.L. 101-239, §6503(b)(4), amended paragraph (1) in its entirety, applicable to payments for allotments for fiscal years beginning with fiscal year 1991. [For paragraph (1) as it formerly read, see Vol. III, P.L. 101-239.]

[31] P.L. 101-239, §6503(b)(4), added paragraph (2), applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[32] P.L. 101-239, §6503(b)(4), added paragraph (3), applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

being provided solely by such State for maternal and child health programs at a level at least equal to the level that such State provided for such programs in fiscal year 1989; and[33]

(5)[34] provides[35] that—

(A) the State will establish[36] a fair method (as determined by the State) for allocating funds allotted to the State under this title among such individuals, areas, and localities identified under paragraph (1)(A) as needing maternal and child health services, and the State will identify and apply guidelines for the appropriate frequency and content of, and appropriate referral and followup with respect to, health care assessments and services financially assisted by the State under this title and methods for assuring quality assessments and services;

(B) funds allotted to the State under this title will only be used, consistent with section 508, to carry out the purposes of this title or to continue activities previously conducted under the consolidated health programs (described in section 501(b)(1));

(C) the State will use—

(i) special consideration (where appropriate) for the continuation of the funding of special projects in the State previously funded under this title (as in effect before August 31, 1981), and[37]

(ii) a reasonable proportion (based upon the State's previous use of funds under this title) of such sums to carry out the purposes described in subparagraphs (A) through (D) of section 501(a)(1)[38] ;

(D) if any charges are imposed for the provision of health services assisted by the State under this title, such charges (i) will be pursuant to a public schedule of charges, (ii) will not be imposed with respect to services provided to low income mothers or children, and (iii) will be adjusted to reflect the income, resources, and family size of the individual provided the services;[39]

(E) the State agency (or agencies) administering the State's program under this title will provide for a toll-free telephone number (and other appropriate methods) for the use of parents to access information about health care providers and practitioners who provide health care services under this title and title XIX and about other relevant health and health-related providers and practitioners; and[40]

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[33] P.L. 101-239, §6503(b)(4), added paragraph (4), applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[34] P.L. 101-239, §6503(b)(4), redesignated paragraph (2) as paragraph (5).

[35] P.L. 101-239, §6503(b)(5)(A), struck out "a statement of assurances that represents to the Secretary", and substituted "provides", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[36] P.L. 101-239, §6503(b)(5)(B), struck out "provide" and substituted "establish", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[37] P.L. 101-239, §6503(b)(5)(C), amended clause (i) in its entirety, applicable to payments for allotments for fiscal years beginning with fiscal year 1991. [For clause (i) as it formerly read, see Vol. III, P.L. 101-239.]

[38] P.L. 101-239, §6501(b), struck out "paragraphs (1) through (3) of section 501(a)", and substituted "subparagraphs (A) through (D) of section 501(a)(1)", applicable to appropriations for fiscal years beginning with fiscal year 1990.

[39] P.L. 101-239, §6503(b)(5)(D), struck out "and".

[40] P.L. 101-239, §6503(b)(5)(E), added this subparagraph (E), applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

(F)[41] the State agency (or agencies) administering the State's program under this title will[42]—

(i) participate[43] in the coordination of activities between such program and the early and periodic screening, diagnostic[44], and treatment program under section 1905(a)(4)(B) (including the establishment of periodicity and content standards for early and periodic screening, diagnostic, and treatment services)[45], to ensure that such programs are carried out without duplication of effort,

(ii) participate[46] in the arrangement and carrying out of coordination agreements described in section 1902(a)(11) (relating to coordination of care and services available under this title and title XIX),[47]

(iii) participate[48] in the coordination of activities within the State with programs carried out under this title and related Federal grant programs (including supplemental food programs for mothers, infants, and children, related education programs, and other health, developmental disability, and family planning programs), and[49]

(iv) provide, directly and through their providers and institutional contractors, for services to identify pregnant women and infants who are eligible for medical assistance under subparagraph (A) or (B) of section 1902(l)(1) and, once identified, to assist them in applying for such assistance.[50]

The application shall be developed by, or in consultation with, the State maternal and child health agency and shall be made public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during its development and after its transmittal.[51]

(b) The Secretary may waive the requirements[52] under subsection

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[41] P.L. 101-239, §6503(b)(5)(E), redesignated subparagraph (E) as (F).

[42] P.L. 101-239, §6503(b)(5)(F)(i), struck out "participate", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[43] P.L. 101-239, §6503(b)(5)(F)(iv), inserted "participate", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[44] P.L. 101-239, §6503(b)(5)(F)(ii), struck out "diagnosis" and substituted "diagnostic", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[45] P.L. 101-239, §6503(b)(5)(F)(iii), struck out "title XIX" and substituted "section 1905(a)(4)(B) (including the establishment of periodicity and content standards for early and periodic screening, diagnostic, and treatment services)", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[46] P.L. 101-239, §6503(b)(5)(F)(iv), inserted "participate", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[47] P.L. 101-239, §6503(b)(5)(F)(v), struck out "and".

[48] P.L. 101-239, §6503(b)(5)(F)(iv), inserted "participate", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[49] P.L. 101-239, §6503(b)(5)(F)(vi), struck out the period and substituted ", and".

[50] P.L. 101-239, §6503(b)(5)(F)(vii), added clause (iv), applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[51] P.L. 101-239, §6503(b)(6), struck out "The description and statement shall be made public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during development of the description and statement and after its transmittal. The description and statement shall be revised (consistent with this section) throughout the year as may be necessary to reflect substantial changes in any element of such description or statement, and any revision shall be subject to the requirements of the preceding sentence." and substituted this sentence, applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[52] P.L. 101-508, §4755(c)(3), struck out "requirement" and substituted "requirements", effective November 5, 1990.

(a)(3) that a State's application for a fiscal year provide for the use of funds for specific activities if for that fiscal year—

(1) the Secretary determines—

(A) on the basis of information provided in the State's most recent annual report submitted under section 506(a)(1), that the State has demonstrated an extraordinary unmet need for one of the activities described in subsection (a)(3), and

(B) that the granting of the waiver is justified and will assist in carrying out the purposes of this title; and

(2) the State provides assurances to the Secretary that the State will provide for the use of some amounts paid to it under section 503 for the activities described in subparagraphs (A) and (B) of subsection (a)(3) and specifies the percentages to be substituted in each of such subparagraphs.[53]

REPORTS AND AUDITS

SEC. 506. [42 U.S.C. 706] (a)(1) Each State shall prepare and submit to the Secretary annual reports on its activities under this title. Each such report shall be prepared by, or in consultation with, the State maternal and child health agency.[54] In order properly to evaluate and to compare the performance of different States assisted under this title and to assure the proper expenditure of funds under this title, such reports shall be in such standardized form and contain such information (including information described in paragraph (2))[55] as the Secretary determines (after consultation with the States and the Comptroller General) to be necessary (A) to secure an accurate description of those activities, (B) to secure a complete record of the purposes for which funds were spent, of the recipients of such funds,,[56] (C) to describe the extent to which the State has met the goals and objectives it set forth under section 505(a)(2)(B)(i) and the national health objectives referred to in section 501(a) and (D)[57] to determine the extent to which funds were expended consistent with the State's application[58] transmitted under section 505(a)[59]. Copies of the report shall be provided, upon request, to any interested public agency, and each such agency may provide its views on these reports to the Congress.

(2) Each annual report under paragraph (1) shall include the following information:

(A)(i) The number of individuals served by the State under this title (by class of individuals).

(ii) The proportion of each class of such individuals which has health coverage.

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[53] P.L. 101-239, §6503(b)(7), added subsection (b), applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[54] P.L. 101-239, §6504(a)(1)(A), inserted this sentence, applicable to annual reports for fiscal years beginning with fiscal year 1991.

[55] P.L. 101-239, §6504(a)(1)(B), struck out "form and contain such information" and inserted "standardized form and contain such information (including information described in paragraph (2))", applicable to annual reports for fiscal years beginning with fiscal year 1991.

[56] As in original.

[57] P.L. 101-239, §6504(a)(1)(C), struck out "and of the progress made toward achieving the purposes of this title, and (C)" and substituted a comma, this subparagraph (C), and "(D)", applicable to annual reports for fiscal years beginning with fiscal year 1991.

[58] P.L.101-239, §6503(c)(3), struck out "description and statement" and substituted "application", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[59] P.L. 101-239, §6503(c)(4), inserted "(a)", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

(iii) The types (as defined by the Secretary) of services provided under this title to individuals within each such class.

(iv) The amounts spent under this title on each type of services, by class of individuals served.

(B) Information on the status of maternal and child health in the State, including—

(i) information (by county and by racial and ethnic group) on—

(I) the rate of infant mortality, and

(II) the rate of low-birth-weight births;

(ii) information (on a State-wide basis) on—

(I) the rate of maternal mortality,

(II) the rate of neonatal death,

(III) the rate of perinatal death,

(IV) the number of children with chronic illness and the type of illness,

(V) the proportion of infants born with fetal alcohol syndrome,

(VI) the proportion of infants born with drug dependency,

(VII) the proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy, and

(VIII) the proportion of children, who at their second birthday, have been vaccinated against each of measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitis B; and

(iii) information on such other indicators of maternal, infant, and child health care status as the Secretary may specify.

(C) Information (by racial and ethnic group) on—

(i) the number of deliveries in the State in the year, and

(ii) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under the State plan under title XIX in the year.

(D) Information (by racial and ethnic group) on—

(i) the number of infants under one year of age who were in the State in the year, and

(ii) the number of such infants who were provided services under this title or were entitled to benefits under the State plan under title XIX at any time during the year.

(E) Information on the number of—

(i) obstetricians,

(ii) family practitioners,

(iii) certified family nurse practitioners,

(iv) certified nurse midwives,

(v) pediatricians, and

(vi) certified pediatric nurse practitioners,

who were licensed in the State in the year.

For purposes of subparagraph (A), each of the following shall be considered to be a separate class of individuals: pregnant women, infants up to age one, children with special health care needs, other children under age 22, and other individuals.[60]

(3) The Secretary shall annually transmit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report that includes—

(A) a description of each project receiving funding under paragraph (2) or (3) of section 502(a), including the amount of Federal funds provided, the number of individuals served or trained, as appropriate, under the project, and a summary of any formal evaluation conducted with respect to the project;

(B) a summary of the information described in paragraph (2)(A) reported by States;

(C) based on information described in paragraph (2)(B) supplied by the States under paragraph (1), a compilation of the following measures of maternal and child health in the United States and in each State:

(i) Information on—

(I) the rate of infant mortality, and

(II) the rate of low-birth-weight births.

Information under this clause shall also be compiled by racial and ethnic group.

(ii) Information on—

(I) the rate of maternal mortality,

(II) the rate of neonatal death,

(III) the rate of perinatal death,

(IV) the proportion of infants born with fetal alcohol syndrome,

(V) the proportion of infants born with drug dependency,

(VI) the proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy, and

(VII) the proportion of children, who at their second birthday, have been vaccinated against each of measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitis B.

(iii) Information on such other indicators of maternal, infant, and child health care status as the Secretary has specified under paragraph (2)(B)(iii).

(iv) Information (by racial and ethnic group) on—

(I) the number of deliveries in the State in the year, and

(II) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under the State plan under title XIX in the year;

(D) based on information described in subparagraphs (C), (D), and (E) of paragraph (2) supplied by the States under paragraph (1), a compilation of the following information in the United States and in each State:

(i) Information on—

(I) the number of deliveries in the year, and

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[60] P.L. 101-239, §6504(a)(3), added this paragraph (2), applicable to annual reports for fiscal years beginning with fiscal year 1991.

(II) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under a State plan under title XIX in the year.

Information under this clause shall also be compiled by racial and ethnic group.

(ii) Information on—

(I) the number of infants under one year of age in the year, and

(II) the number of such infants who were provided services under this title or were entitled to benefits under a State plan under title XIX at any time during the year.

Information under this clause shall also be compiled by racial and ethnic group.

(iii) Information on the number of—

(I) obstetricians,
(II) family practitioners,
(III) certified family nurse practitioners,
(IV) certified nurse midwives,
(V) pediatricians, and
(VI) certified pediatric nurse practitioners,

who were licensed in a State in the year; and

(E) an assessment of the progress being made to meet the health status goals and national health objectives referred to in section 501(a).[61]

(b)(1) Each State shall, not less often than once every two years, audit its expenditures from amounts received under this title. Such State audits shall be conducted by an entity independent of the State agency administering a program funded under this title in accordance with the Comptroller General's standards for auditing governmental organizations, programs, activities, and functions and generally accepted auditing standards. Within 30 days following the completion of each audit report, the State shall submit a copy of that audit report to the Secretary.

(2) Each State shall repay to the United States amounts found by the Secretary, after notice and opportunity for a hearing to the State, not to have been expended in accordance with this title and, if such repayment is not made, the Secretary may offset such amounts against the amount of any allotment to which the State is or may become entitled under this title or may otherwise recover such amounts.

(3) The Secretary may, after notice and opportunity for a hearing, withhold payment of funds to any State which is not using its allotment under this title in accordance with this title. The Secretary may withhold such funds until the Secretary finds that the reason for the withholding has been removed and there is reasonable assurance that it will not recur.

(c) The State shall make copies of the reports and audits required by this section available for public inspection within the State.

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[61] P.L. 101-239, §6504(a)(2), redesignated paragraph (2) as paragraph (3) and §6504(b) amended paragraph (3) in its entirety, applicable to annual reports for fiscal years beginning with fiscal year 1991. [For paragraph (3) as it formerly read, see Vol. III, P.L. 101-239.]

(d)(1) For the purpose of evaluating and reviewing the block grant established under this title, the Secretary and the Comptroller General shall have access to any books, accounts, records, correspondence, or other documents that are related to such block grant, and that are in the possession, custody, or control of States, political subdivisions thereof, or any of their grantees.

(2) In conjunction with an evaluation or review under paragraph (1), no State or political subdivision thereof (or grantee of either) shall be required to create or prepare new records to comply with paragraph (1).

(3) For other provisions relating to deposit, accounting, reports, and auditing with respect to Federal grants to States, see section 6503(b) of title 31, United States Code.

CRIMINAL PENALTY FOR FALSE STATEMENTS

Sec. 507. [42 U.S.C. 707] (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in connection with the furnishing of items or services for which payment may be made by a State from funds allotted to the State under this title, or

(2) having knowledge of the occurrence of any event affecting his initial or continued right to any such payment conceals or fails to disclose such event with an intent fraudulently to secure such payment either in a greater amount than is due or when no such payment is authorized,

shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(b) For civil monetary penalties for certain submissions of false claims, see section 1128A of this Act.

NONDISCRIMINATION

Sec. 508. [42 U.S.C. 708] (a)(1) For the purpose of applying the prohibitions against discrimination on the basis of age under the Age Discrimination Act of 1975[62], on the basis of handicap under section 504 of the Rehabilitation Act of 1973[63], on the basis of sex under title IX of the Education Amendments of 1972[64], or on the basis of race, color, or national origin under title VI of the Civil Rights Act of 1964[65], programs and activities funded in whole or in part with funds made available under this title are considered to be programs and activities receiving Federal financial assistance.

(2) No person shall on the ground of sex or religion be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded in whole or in part with funds made available under this title.

(b) Whenever the Secretary finds that a State, or an entity that has received a payment from an allotment to a State under section 502(c)[66], has failed to comply with a provision of law referred to in subsection (a)(1), with subsection (a)(2), or with an applicable regulation (including one prescribed to carry out subsection (a)(2)), he shall notify the chief executive officer of the State and shall request him to secure compliance. If within a reasonable period of time, not to exceed sixty days, the chief executive officer fails or refuses to secure compliance, the Secretary may—

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[62] P.L. 94-135, Title III [89 Stat. 728].

[63] P.L. 93-112.

[64] P.L. 92-318.

[65] P.L. 88-352.

[66] P.L. 101-239, §6502(b), struck out "502(b)" and substituted "502(c)", applicable to appropriations for fiscal years beginning with fiscal year 1990.

(1) refer the matter to the Attorney General with a recommendation that an appropriate civil action be instituted,

(2) exercise the powers and functions provided by title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973, as may be applicable, or

(3) take such other action as may be provided by law.

(c) When a matter is referred to the Attorney General pursuant to subsection (b)(1), or whenever he has reason to believe that the entity is engaged in a pattern or practice in violation of a provision of law referred to in subsection (a)(1) or in violation of subsection (a)(2), the Attorney General may bring a civil action in any appropriate district court of the United States for such relief as may be appropriate, including injunctive relief.

ADMINISTRATION OF TITLE AND STATE PROGRAMS

SEC. 509. [42 U.S.C. 709] (a) The Secretary shall designate an identifiable administrative unit with expertise in maternal and child health within the Department of Health and Human Services, which unit shall be responsible for—

(1) the Federal program described in section 502(a);

(2) promoting coordination at the Federal level of the activities authorized under this title and under title XIX of this Act, especially early and periodic screening, diagnosis and treatment, related activities funded by the Departments of Agriculture and Education, and under health block grants and categorical health programs, such as immunizations, administered by the Secretary;

(3) disseminating information to the States in such areas as preventive health services and advances in the care and treatment of mothers and children;

(4) providing technical assistance, upon request, to the States in such areas as program planning, establishment of goals and objectives, standards of care, and evaluation and in developing consistent and accurate data collection mechanisms in order to report the information required under section 506(a)(2)[67];

(5) in cooperation with the National Center for Health Statistics and in a manner that avoids duplication of data collection, collection, maintenance, and dissemination of information relating to the health status and health service needs of mothers and children in the United States;[68]

(6) assisting in the preparation of reports to the Congress on

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[67] P.L. 101-239, §6505(1), inserted "and in developing consistent and accurate data collection mechanisms in order to report the information required under section 506(a)(2)", applicable to appropriations for fiscal years beginning with fiscal year 1990.

[68] P.L. 101-239, §6505(2), struck out "and".

the activities funded and accomplishments achieved under this title from the information required to be reported by the States under sections 505(a)[69] and 506; and[70]

(7) assisting States in the development of care coordination services (as defined in section 501(b)(3)); and[71]

(8) developing and making available to the State agency (or agencies) administering the State's program under this title a national directory listing by State the toll-free numbers described in section 505(a)(5)(E).[72]

(b) The State health agency of each State shall be responsible for the administration (or supervision of the administration) of programs carried out with allotments made to the State under this title, except that, in the case of a State which on July 1, 1967, provided for administration (or supervision thereof) of the State plan under this title (as in effect on such date) by a State agency other than the State health agency, that State shall be considered to comply[73] the requirement of this subsection if it would otherwise comply but for the fact that such other State agency administers (or supervises the administration of) any such program providing services for children with special health care needs.

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[69] P.L. 101-239, §6503(c)(4), inserted "(a)", applicable to payments for allotments for fiscal years beginning with fiscal year 1991.

[70] P.L. 101-239, §6505(3), struck out the period and substituted "; and".

[71] P.L. 101-239, §6505(4), added paragraph (7), applicable to appropriations for fiscal years beginning with fiscal year 1990.

[72] P.L. 101-239, §6505(4), added paragraph (8), applicable to appropriations for fiscal years beginning with fiscal year 1990.

[73] As in original.

[TITLE VI—GRANTS TO STATES FOR SERVICES TO THE AGED, BLIND, OR DISABLED][1]

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[1] P.L. 92-603, §302, 86 Stat. 1478, added Title VI, effective January 1, 1974.
P.L. 93-647, §3(b), 88 Stat. 2349, repealed Title VI, effective with respect to payments under §603 of this Act for quarters commencing after September 30, 1975.

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TITLE VII—ADMINISTRATION[1]

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OFFICE OF COMMISSIONER FOR SOCIAL SECURITY[3]

SECTION 701. [42 U.S.C. 901] There shall be in the Department of Health and Human Services a Commissioner for Social Security, appointed by the Secretary, who shall perform such functions relating to social security as the Secretary shall assign to him.

DUTIES OF SOCIAL SECURITY BOARD[4]

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[1] Title VII of the Social Security Act is administered by the Office of the Secretary, Office of Commissioner for Social Security, and Department of Health and Human Services.

Title VII appears in the United States Code as §§901-911 of subchapter VII, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services (formerly Secretary of Health, Education, and Welfare) relating to Title VII are contained in subtitle A and chapter II, Title 45, Code of Federal Regulations.

See Vol. II, 31 U.S.C. 6504-6505, with respect to intergovernmental cooperation.

See Vol. II, P.L. 88-352, §601, for prohibition against discrimination in federally assisted programs.

[2] This table of contents does not appear in the law.

[3] Although §701 has not been repealed, Reorganization Plan No. 1 of 1953, effective April 11, 1953 (18 F.R. 2053; 67 Stat. 631), in §8, abolished the office of Commissioner for Social Security in the Federal Security Agency, and in §4, provided for a Commissioner of Social Security in the Department of Health, Education, and Welfare [now Department of Health and Human Services], who shall be appointed by the President by and with the advice and consent of the Senate.

[4] P.L. 74-271, §702; 49 Stat. 636.

P.L. 74-271, §702, effective August 14, 1935, imposed these duties on the Social Security Board.

Reorganization Plan No. 2 of 1949 transferred to the Secretary of Labor certain duties and functions of the Federal Security Administrator (now the Secretary of Health and Human Services), with respect to employment services, unemployment compensation, and the Bureau of Employment Security (which also was transferred to the Department of Labor from the Federal Security Agency). Reorganization Plan No. 19 of 1950 transferred the Bureau of Employees' Compensation from the Federal Security Agency (now the Department of Health and Human Services) to the Department of Labor and provided for the transfer from the Federal Security Administrator to the Secretary of Labor of certain functions and duties with respect to the Bureau of Employees' Compensation and with respect to employees' compensation, including workmen's compensation. In effect, with respect to these functions and duties, the provisions of this section of the Social Security Act also apply to the Secretary of Labor.

SEC. 702. [42 U.S.C. 902] The Secretary shall perform the duties imposed upon him by this Act and shall also have the duty of studying and making recommendations as to the most effective methods of providing economic security through social insurance, and as to legislation and matters of administrative policy concerning old-age pensions, unemployment compensation, accident compensation, and related subjects.

EXPENSES OF THE BOARD[5]

SEC. 703. [42 U.S.C. 903] The Secretary is authorized to appoint and fix the compensation of such officers and employees, and to make such expenditures, as may be necessary for carrying out his functions under this Act. Appointments of attorneys and experts may be made without regard to the civil-service laws.

REPORTS

SEC. 704. [42 U.S.C. 904] The Secretary shall make a full report to Congress, within one hundred and twenty days after the beginning of each regular session, of the administration of the functions with which he is charged under this Act. In addition to the number of copies of such report authorized by other law to be printed, there is hereby authorized to be printed not more than five thousand copies of such report for use by the Secretary for distribution to Members of Congress and to State and other public or private agencies or organizations participating in or concerned with the social security program.

TRAINING GRANTS FOR PUBLIC WELFARE PERSONNEL

SEC. 705. [42 U.S.C. 906] (a) In order to assist in increasing the effectiveness and efficiency of administration of public assistance programs by increasing the number of adequately trained public welfare personnel available for work in public assistance programs, there are hereby authorized to be appropriated for the fiscal year ending June 30, 1963, the sum of $3,500,000, and for each fiscal year thereafter the sum of $5,000,000.

(b) Such portion of the sums appropriated pursuant to subsection (a) for any fiscal year as the Secretary may determine, but not in excess of $1,000,000 in the case of the fiscal year ending June 30, 1963, and $2,000,000 in the case of any fiscal year thereafter, shall be available for carrying out subsection (f). From the remainder of the sums so appropriated for any fiscal year, the Secretary shall make allotments to the States on the basis of (1) population, (2) relative need for trained public welfare personnel, particularly for personnel to provide self-support and self-care services, and (3) financial need.

(c) From each State's allotment under subsection (b), the Secretary shall from time to time pay to such State its costs of carrying out the purposes of this section through (1) grants to public or other nonprofit institutions of higher learning for training personnel employed or preparing for employment in public assistance programs, (2) special courses of study or seminars of short duration conducted for such personnel by experts hired on a temporary basis for the purpose, and (3) establishing and maintaining, directly or through grants to such institutions, fellowships or traineeships for such personnel at such institutions, with such stipends and allowances as may be permitted under regulations of the Secretary.

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[5] P.L. 74-271, §703; 49 Stat. 636.

(d) Payments pursuant to subsection (c) shall be made in advance on the basis of estimates by the Secretary and adjustments may be made in future payments under this section to take account of overpayments or underpayments in amounts previously paid.

(e) The amount of any allotment to a State under subsection (b) for any fiscal year which the State certifies to the Secretary will not be required for carrying out the purposes of this section in such State shall be available for reallotment from time to time, on such dates as the Secretary may fix, to other States which the Secretary determines have need in carrying out such purposes for sums in excess of those previously allotted to them under this section and will be able to use such excess amounts during such fiscal year; such reallotments to be made on the basis provided in subsection (b) for the initial allotments to the States. Any amount so reallotted to a State shall be deemed part of its allotment under such subsection.

(f)(1) The portion of the sums appropriated for any fiscal year which is determined by the Secretary under the first sentence of subsection (b) to be available for carrying out this subsection shall be available to enable him to provide (A) directly or through grants to or contracts with public or nonprofit private institutions of higher learning, for training personnel who are employed or preparing for employment in the administration of public assistance programs, (B) directly or through grants to or contracts with public or nonprofit private agencies or institutions, for special courses of study or seminars of short duration (not in excess of one year) for training of such personnel, and (C) directly or through grants to or contracts with public or nonprofit private institutions of higher learning, for establishing and maintaining fellowships or traineeships for such personnel at such institutions, with such stipends and allowances as may be permitted by the Secretary.

(2) Payments under paragraph (1) may be made in advance on the basis of estimates by the Secretary, or may be made by way of reimbursement, and adjustments may be made in future payments under this subsection to take account of overpayments or underpayments in amounts previously paid.

(3) The Secretary may, to the extent he finds such action to be necessary, prescribe requirements to assure that any individual will repay the amount of his fellowship or traineeship received under this subsection to the extent such individual fails to serve, for the period prescribed by the Secretary, with a State or political subdivision thereof, or with the Federal Government, in connection with administration of any State or local public assistance program. The Secretary may relieve any individual of his obligation to so repay, in whole or in part, whenever and to the extent that requirement of such repayment would, in his judgment, be inequitable or would be contrary to the purposes of any of the public welfare programs established by this Act.

ADVISORY COUNCIL ON SOCIAL SECURITY[6]

SEC. 706. [42 U.S.C. 907] (a) During 1969 (but not before February 1, 1969) and every fourth year thereafter (but not before February 1 of such fourth year), except as provided in subsection (e), the Secretary shall appoint an Advisory Council on Social Security for the purpose of reviewing the status of the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust Fund in relation to the long-term commitments of the old-age, survivors, and disability insurance program and the programs under parts A and B of title XVIII, and of reviewing the scope of coverage and the adequacy of benefits under, and all other aspects of, these programs, including their impact on the public assistance programs under this Act.

(b) Each such Council shall consist of a Chairman and 12 other persons, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The appointed members shall, to the extent possible, represent organizations of employers and employees in equal numbers, and represent self-employed persons and the public.

(c)(1) Any Council appointed hereunder is authorized to engage such technical assistance, including actuarial services, as may be required to carry out its functions, and the Secretary shall, in addition, make available to such Council such secretarial, clerical, and other assistance and such actuarial and other pertinent data prepared by the Department of Health and Human Services as it may require to carry out such functions.

(2) Appointed members of any such Council, while serving on business of the Council (inclusive of travel time), shall receive compensation at rates fixed by the Secretary, but not exceeding $100 per day and, while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

(d) Each such Council shall submit reports (including any interim reports such Council may have issued) of its findings and recommendations to the Secretary not later than January 1 of the second year after the year in which it is appointed, and such reports and recommendations shall thereupon be transmitted to the Congress and to the Board of Trustees of each of the Trust Funds. The reports required by this subsection shall include—

(1) a separate report with respect to the old-age, survivors, and disability insurance program under title II and of the taxes imposed under sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1954[7],

(2) a separate report with respect to the hospital insurance program under part A of title XVIII and of the taxes imposed by sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1954, and

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[6] See Vol. II, P.L. 92-463, §§2-15, with respect to provisions governing the operation of advisory committees.

[7] See P.L. 83-591, §1401 (this volume).

(3) a separate report with respect to the supplementary medical insurance program established by part B of title XVIII and of the financing thereof.

After the date of the transmittal to the Congress of the reports required by this subsection, the Council shall cease to exist.

(e) No Advisory Council on Social Security shall be appointed under subsection (a) in 1985 (or in any subsequent year prior to 1989).

GRANTS FOR EXPANSION AND DEVELOPMENT OF UNDERGRADUATE AND GRADUATE PROGRAMS

SEC. 707. [42 U.S.C. 908] (a) There is authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1969, and $5,000,000 for each of the three succeeding fiscal years, for grants by the Secretary to public or nonprofit private colleges and universities and to accredited graduate schools of social work or an association of such schools to meet part of the costs of development, expansion, or improvement of (respectively) undergraduate programs in social work and programs for the graduate training of professional social work personnel, including the costs of compensation of additional faculty and administrative personnel and minor improvements of existing facilities. Not less than one-half of the sums appropriated for any fiscal year under the authority of this subsection shall be used by the Secretary for grants with respect to undergraduate programs.

(b) In considering applications for grants under this section, the Secretary shall take into account the relative need in the States for personnel trained in social work and the effect of the grants thereon.

(c) Payment of grants under this section may be made (after necessary adjustments on account of previously made overpayments or underpayments) in advance or by way of reimbursement, and on such terms and conditions and in such installments, as the Secretary may determine.

(d) For purposes of this section—

(1) the term "graduate school of social work" means a department, school, division, or other administrative unit, in a public or nonprofit private college or university, which provides, primarily or exclusively, a program of education in social work and allied subjects leading to a graduate degree in social work;

(2) the term "accredited" as applied to a graduate school of social work refers to a school which is accredited by a body or bodies approved for the purpose by the Commissioner of Education or with respect to which there is evidence satisfactory to the Secretary that it will be so accredited within a reasonable time; and

(3) the term "nonprofit" as applied to any college or university refers to a college or university which is a corporation or association, or is owned and operated by one or more corporations or associations, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

DELIVERY OF BENEFIT CHECKS

SEC. 708. [42 U.S.C. 909] (a) If the day regularly designated for the delivery of benefit checks under title II or title XVI falls on a

Saturday, Sunday, or legal public holiday (as defined in section 6103 of title 5, United States Code[8]) in any month, the benefit checks which would otherwise be delivered on such day shall be mailed for delivery on the first day preceding such day which is not a Saturday, Sunday, or legal public holiday (as so defined), without regard to whether the delivery of such checks would as a result have to be made before the end of the month for which such checks are issued.

(b) If more than the correct amount of payment under title II or XVI is made to any individual as a result of the receipt of a benefit check pursuant to subsection (a) before the end of the month for which such check is issued, no action shall be taken (under section 204 or 1631(b) or otherwise) to recover such payment or the incorrect portion thereof.

(c) For purposes of computing the "OASDI trust fund ratio" under section 201(l), the "OASDI fund ratio" under section 215(i), and the "balance ratio" under section 709(b), benefit checks delivered before the end of the month for which they are issued by reason of subsection (a) of this section shall be deemed to have been delivered on the regularly designated delivery date.

RECOMMENDATIONS BY BOARD OF TRUSTEES TO REMEDY INADEQUATE BALANCES IN THE SOCIAL SECURITY TRUST FUNDS

SEC. 709. [42 U.S.C. 910] (a) If the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, or the Federal Supplementary Medical Insurance Trust Fund determines at any time that the balance ratio of any such Trust Fund for any calendar year may become less than 20 percent, the Board shall promptly submit to each House of the Congress a report setting forth its recommendations for statutory adjustments affecting the receipts and disbursements of such Trust Fund necessary to maintain the balance ratio of such Trust Fund at not less than 20 percent, with due regard to the economic conditions which created such inadequacy in the balance ratio and the amount of time necessary to alleviate such inadequacy in a prudent manner. The report shall set forth specifically the extent to which benefits would have to be reduced, taxes under section 1401, 3101, or 3111 of the Internal Revenue Code of 1954[9] would have to be increased, or a combination thereof, in order to obtain the objectives referred to in the preceding sentence.

(b) For purposes of this section, the term "balance ratio" means, with respect to any calendar year in connection with any Trust Fund referred to in subsection (a), the ratio of—

(1) the balance in such Trust Fund as of the beginning of such year, including the taxes transferred under section 201(a) on the first day of such year and reduced by the outstanding amount of any loan (including interest thereon) theretofore made to such Trust Fund under section 201(l) or 1817(j), to

(2) the total amount which (as estimated by the Secretary) will be paid from such Trust Fund during such calendar year for all purposes authorized by section 201, 1817, or 1841 (as applicable),

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[8] Legal public holidays which may affect check delivery are (1) New Year's Day [January 1], (2) Independence Day [July 4], and (3) Labor Day [first Monday in September].

[9] See P.L. 83-591, §1401 (this volume).

other than payments of interest on, or repayments of, loans under section 201(l) or 1817(j), but excluding any transfer payments between such Trust Fund and any other Trust Fund referred to in subsection (a) and reducing the amount of any transfers to the Railroad Retirement Account by the amount of any transfers into such Trust Fund from that Account.

BUDGETARY TREATMENT OF TRUST FUND OPERATIONS[10]

SEC. 710. [42 U.S.C. 911] (a) The receipts and disbursements of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, and the taxes imposed under sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1954[11], shall not be included in the totals of the budget of the United States Government as submitted by the President or of the congressional budget and shall be exempt from any general budget limitation imposed by statute on expenditures and net lending (budget outlays) of the United States Government.[12]

(b)[13] The disbursements of[14] the Federal Hospital Insurance Trust Fund[15] and the Federal Supplementary Medical Insurance Trust Fund shall be treated as a separate major functional category in the budget of the United States Government as submitted by the President and in the congressional budget, and the receipts of such Trust Funds, including the taxes imposed under sections 1401(b), 3101(b), and 3111(b)[16] of the Internal Revenue Code of 1954[17], shall be set forth separately in such budgets.

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[10] P.L. 98-21, §346(a)(1), added §710, effective with respect to fiscal years beginning on or after October 1, 1984, and ending on or before September 30, 1992, except that such amendment shall apply with respect to the fiscal year beginning on October 1, 1983, to the extent it relates to the congressional budget. For fiscal years beginning on or after October 1, 1992, §710 reads as follows:

"BUDGETARY TREATMENT OF TRUST FUND OPERATIONS

"Sec. 710. (a)(1)[*]The receipts and disbursements of the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and the Federal Hospital Insurance Trust Fund and the taxes imposed under sections 1401, 3101, and 3111 of the Internal Revenue Code of 1954 shall not be included in the totals of the budget of the United States Government as submitted by the President or of the congressional budget and shall be exempt from any general budget limitation imposed by statute on expenditures and net lending (budget outlays) of the United States Government.

"(2) No provision of law enacted after the date of the enactment of the Balanced Budget and Emergency Deficit Control Act of 1985 (other than a provision of an appropriation Act that appropriates funds authorized under the Social Security Act as in effect on the date of the enactment of the Balanced Budget and Emergency Deficit Control Act of 1985) may provide for payments from the general fund of the Treasury to any Trust Fund specified in paragraph (1) or for payments from any such Trust Fund to the general fund of the Treasury.[**]

"(b) The disbursements of the Federal Supplementary Medical Insurance Trust Fund shall be treated as a separate major functional category in the budget of the United States Government as submitted by the President and in the congressional budget, and the receipts of such Trust Fund shall be set forth separately in such budgets.".

[*] P.L. 99-177, §261(b)(1), inserted "(1)", effective with respect to fiscal years beginning on or after October 1, 1992.

[**] P.L. 99-177, §261(b)(2), added subsection (a)(2), effective with respect to fiscal years beginning on or after October 1, 1992.

See Vol. II, P.L. 93-344, §3(2), with respect to budget authority for fiscal year 1992 and subsequent fiscal years.

[11] See P.L. 83-591, §1401 (this volume).

[12] P.L. 99-177, §261(a)(1)(E), added subsection (a), effective with respect to fiscal years beginning after September 30, 1985, and ending before October 1, 1992.

[13] P.L. 99-177, §261(a)(1)(D), redesignated as subsection (b) all of the section that formerly followed the section number, effective with respect to fiscal years beginning after September 30, 1985, and ending before October 1, 1992.

[14] P.L. 99-177, §261(a)(1)(A), struck out "the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund,", effective with respect to fiscal years beginning after September 30, 1985, and ending before October 1, 1992.

[15] P.L. 99-177, §261(a)(1)(B), struck out a comma, effective with respect to fiscal years beginning after September 30, 1985, and ending before October 1, 1992.

[16] P.L. 99-177, §261(a)(1)(C), struck out "1401, 3101, and 3111" and substituted "1401(b), 3101(b), and 3111(b)", effective with respect to fiscal years beginning after September 30, 1985, and ending before October 1, 1992.

(c) No provision of law enacted after the date of the enactment of the Balanced Budget and Emergency Deficit Control Act of 1985[18] (other than a provision of an appropriation Act that appropriates funds authorized under the Social Security Act as in effect on the date of the enactment of the Balanced Budget and Emergency Deficit Control Act of 1985) may provide for payments from the general fund of the Treasury to the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund, or for payments from either such Trust Fund to the general fund of the Treasury.[19]

OFFICE OF RURAL HEALTH POLICY

SEC. 711. [42 U.S.C. 912] (a) There shall be established in the Department of Health and Human Services (in this section referred to as the "Department") an Office of Rural Health Policy (in this section referred to as the "Office"). The Office shall be headed by a Director, who shall advise the Secretary on the effects of current policies and proposed statutory, regulatory, administrative, and budgetary changes in the programs established under titles XVIII and XIX on the financial viability of small rural hospitals, the ability of rural areas (and rural hospitals in particular) to attract and retain physicians and other health professionals, and access to (and the quality of) health care in rural areas.

(b) In addition to advising the Secretary with respect to the matters specified in subsection (a), the Director, through the Office, shall—

(1) oversee compliance with the requirements of section 1102(b) of this Act and section 4403 of the Omnibus Budget Reconciliation Act of 1987[20] (as such section pertains to rural health issues),

(2) establish and maintain a clearinghouse for collecting and disseminating information on—

(A) rural health care issues, including rural mental health, rural infant mortality prevention, and rural occupational safety and preventive health promotion[21],

(B) research findings relating to rural health care, and

(C) innovative approaches to the delivery of health care in rural area, including programs providing community-based mental health services, pre-natal and infant care services, and rural occupational safety and preventive health education and promotion[22],

(3) coordinate the activities within the Department that relate to rural health care, and

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[17] See P.L. 83-591, §1401 (this volume).

[18] December 12, 1985 [P.L. 99-177; 99 Stat. 1037].

[19] P.L. 99-177, §261(a)(1)(F), added subsection (c), effective with respect to fiscal years beginning after September 30, 1985, and ending before October 1, 1992.

[20] P.L. 100-203.

[21] P.L. 101-239, §6213(g)(1), struck out "health care issues" and substituted "health care issues, including rural mental health, rural infant mortality prevention, and rural occupational safety and preventive health promotion", effective December 19, 1989.

[22] P.L. 101-239, §6213(g)(2), struck out "rural areas" and substituted "rural areas, including programs providing community-based mental health services, pre-natal and infant care services, and rural occupational safety and preventive health education and promotion", effective December 19, 1989.

(4) provide information to the Secretary and others in the Department with respect to the activities, of other Federal departments and agencies, that relate to rural health care, including activities relating to rural mental health, rural infant mortality, and rural occupational safety and preventive health promotion.[23]

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[23] P.L. 101-239, §6213(g)(3), struck out "rural health care" and substituted "rural health care, including activities relating to rural mental health, rural infant mortality, and rural occupational safety and preventive health promotion", effective December 19, 1989.

[TITLE VIII—TAXES WITH RESPECT TO EMPLOYMENT][1]

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[1] P.L. 74-271, 49 Stat. 620, approved August 14, 1935, included Title VIII.

P.L. 76-1, §4, 53 Stat. 1, repealed Title VIII, effective February 11, 1939. The substance of Title VIII then was included in the Internal Revenue Code of 1939 at §§1400-1425. Currently, the substance of Title VIII may be found in the Internal Revenue Code of 1954 at §§3101-3126 (Subtitle C—Employment Taxes; Chapter 21—Federal Insurance Contributions Act), p. 1101.

TITLE IX—MISCELLANEOUS PROVISIONS RELATING TO EMPLOYMENT SECURITY[1]

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[1] Title IX of the Social Security Act is administered by the Department of Labor.

Title IX appears in the United States Code as §§1101-1109, subchapter IX, chapter 7, Title 42.

Regulations of the Secretary of Labor relating to Title IX are contained in chapter V, Title 20, Code of Federal Regulations.

See Vol. II, 31 U.S.C. 6504-6505, with respect to intergovernmental cooperation.

See Vol. II, P.L. 88-352, §601, for prohibition against discrimination in federally assisted programs.

See Vol. II, P.L. 93-618, §§221-249, with respect to adjustment assistance for workers.

See Vol. II, P.L. 95-521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 100-203, §9151, with respect to the determination of the amount of the Federal share of certain extended benefits; and §9152, with respect to a demonstration program to provide self-employment allowances for eligible individuals.

[2] This table of contents does not appear in the law.

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EMPLOYMENT SECURITY ADMINISTRATION ACCOUNT

Establishment of Account

SECTION 901. [42 U.S.C. 1101] (a) There is hereby established in the Unemployment Trust Fund an employment security administration account.

Appropriations to Account

(b)(1) There is hereby appropriated to the Unemployment Trust Fund for credit to the employment security administration account, out of any moneys in the Treasury not otherwise appropriated, for the fiscal year ending June 30, 1961, and for each fiscal year thereafter, an amount equal to 100 per centum of the tax (including interest, penalties, and additions to the tax) received during the fiscal year under the Federal Unemployment Tax Act[3] and covered into the Treasury.

(2) The amount appropriated by paragraph (1) shall be transferred at least monthly from the general fund of the Treasury to the Unemployment Trust Fund and credited to the employment security administration account. Each such transfer shall be based on estimates made by the Secretary of the Treasury of the amounts received in the Treasury. Proper adjustments shall be made in the amounts subsequently transferred, to the extent prior estimates (including estimates for the fiscal year ending June 30, 1960) were in excess of or were less than the amounts required to be transferred.

(3) The Secretary of the Treasury is directed to pay from time to time from the employment security administration account into the Treasury, as repayments to the account for refunding internal revenue collections, amounts equal to all refunds made after June 30, 1960, of amounts received as tax under the Federal Unemployment Tax Act (including interest on such refunds).

Administrative Expenditures

(c)(1) There are hereby authorized to be made available for expenditure out of the employment security administration account for the fiscal year ending June 30, 1971, and for each fiscal year thereafter—

(A) such amounts (not in excess of the applicable limit provided by paragraph (3) and, with respect to clause (ii), not in excess of the limit provided by paragraph (4)) as the Congress may deem appropriate for the purpose of—

(i) assisting the States in the administration of their unemployment compensation laws as provided in title III (including administration pursuant to agreements under any Federal unemployment compensation law),

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[3] The "Federal Unemployment Tax Act" is in §§3301-3311 of P.L. 83-591 (this volume).

(ii) the establishment and maintenance of systems of public employment offices in accordance with the Act of June 6, 1933[4], as amended (29 U.S.C., secs. 49-49n), and

(iii) carrying into effect section 2003 of title 38 of the United States Code;

(B) such amounts (not in excess of the limit provided by paragraph (4) with respect to clause (iii)) as the Congress may deem appropriate for the necessary expenses of the Department of Labor for the performance of its functions under—

(i) this title and titles III and XII of this Act,

(ii) the Federal Unemployment Tax Act,

(iii) the provisions of the Act of June 6, 1933, as amended,

(iv) chapter 41 (except section 2003) of title 38 of the United States Code, and

(v) any Federal unemployment compensation law.

The term "necessary expenses" as used in this subparagraph (B) shall include the expense of reimbursing a State for salaries and other expenses of employees of such State temporarily assigned or detailed to duty with the Department of Labor and of paying such employees for travel expenses, transportation of household goods, and per diem in lieu of subsistence while away from their regular duty stations in the State, at rates authorized by law for civilian employees of the Federal Government.

(2) The Secretary of the Treasury is directed to pay from the employment security administration account into the Treasury as miscellaneous receipts the amount estimated by him which will be expended during a three-month period by the Treasury Department for the performance of its functions under—

(A) this title and titles III and XII of this Act, including the expenses of banks for servicing unemployment benefit payment and clearing accounts which are offset by the maintenance of balances of Treasury funds with such banks,

(B) the Federal Unemployment Tax Act, and

(C) any Federal unemployment compensation law with respect to which responsibility for administration is vested in the Secretary of Labor.

If it subsequently appears that the estimates under this paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Secretary of the Treasury in future payments.

(3)(A) For purposes of paragraph (1)(A), the limitation on the amount authorized to be made available for any fiscal year after June 30, 1970, is, except as provided in subparagraph (B) and in the second sentence of section 901(f)(3)(A), an amount equal to 95 percent of the amount estimated and set forth in the budget of the United States Government for such fiscal year as the amount by which the net receipts during such year under the Federal Unemployment Tax Act will exceed the amount transferred under section 905(b) during such year to the extended unemployment compensation account.

(B) The limitation established by subparagraph (A) is increased by any unexpended amount retained in the employment security administration account in accordance with section 901(f)(2)(B).

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[4] See Vol. II, P.L. 73-30.

(C) Each estimate of net receipts under this paragraph shall be based upon a tax rate of 0.6 percent.

(4) For purposes of paragraphs (1)(A)(ii) and (1)(B)(iii) the amount authorized to be made available out of the employment security administration account for any fiscal year after June 30, 1972, shall reflect the proportion of the total cost of administering the system of public employment offices in accordance with the Act of June 6, 1933[5], as amended, and of the necessary expenses of the Department of Labor for the performance of its functions under the provisions of such Act, as the President determines is an appropriate charge to the employment security administration account, and reflects in his annual budget for such year. The President's determination, after consultation with the Secretary, shall take into account such factors as the relationship between employment subject to State laws and the total labor force in the United States, the number of claimants and the number of job applicants, and such other factors as he finds relevant.

Additional Tax Attributable to Reduced Credits

(d)(1) The Secretary of the Treasury is directed to transfer from the employment security administration account—

(A) To the Federal unemployment account, an amount equal to the amount by which—

(i) 100 per centum of the additional tax received under the Federal Unemployment Tax Act with respect to any State by reason of the reduced credits provisions of section 3302(c)(3) of such Act and covered into the Treasury for the repayment of advances made to the State under section 1201, exceeds

(ii) the amount transferred to the account of such State pursuant to subparagraph (B) of this paragraph.

Any amount transferred pursuant to this subparagraph shall be credited against, and shall operate to reduce, that balance of advances, made under section 1201 to the State, with respect to which employers paid such additional tax.

(B) To the account (in the Unemployment Trust Fund) of the State with respect to which employers paid such additional tax, an amount equal to the amount by which such additional tax received and covered into the Treasury exceeds that balance of advances, made under section 1201 to the State, with respect to which employers paid such additional tax.

(2) Transfers under this subsection shall be as of the beginning of the month succeeding the month in which the moneys were credited to the employment security administration account pursuant to subsection (b)(2).

Revolving Fund

(e)(1) There is hereby established in the Treasury a revolving fund which shall be available to make the advances authorized by this subsection. There are hereby authorized to be appropriated, without fiscal year limitation, to such revolving fund such amounts as may be necessary for the purposes of this section.

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[5] See Vol. II, P.L. 73-30.

(2) The Secretary of the Treasury is directed to advance from time to time from the revolving fund to the employment security administration account such amounts as may be necessary for the purposes of this section. If the net balance in the employment security administration account as of the beginning of any fiscal year equals 40 percent of the amount of the total appropriation by the Congress out of the employment security administration account for the preceding fiscal year, no advance may be made under this subsection during such fiscal year.

(3) Advances to the employment security administration account made under this subsection shall bear interest until repaid at a rate equal to the average rate of interest (computed as of the end of the calendar month next preceding the date of such advance) borne by all interest-bearing obligations of the United States then forming a part of the public debt; except that where such average rate is not a multiple of one-eighth of 1 per centum, the rate of interest shall be the multiple of one-eighth of 1 per centum next lower than such average rate.

(4) Advances to the employment security administration account made under this subsection, plus interest accrued thereon, shall be repaid by the transfer from time to time, from the employment security administration account to the revolving fund, of such amounts as the Secretary of the Treasury, in consultation with the Secretary of Labor, determines to be available in the employment security administration account for such repayment. Any amount transferred as a repayment under this paragraph shall be credited against, and shall operate to reduce, any balance of advances (plus accrued interest) repayable under this subsection.

Determination of Excess and Amount To Be Retained in Employment Security Administration Account

(f)(1) The Secretary of the Treasury shall determine as of the close of each fiscal year (beginning with the fiscal year ending June 30, 1961) the excess in the employment security administration account.

(2)(A) Except as provided in subparagraph (B), the excess in the employment security administration account as of the close of any fiscal year is the amount by which the net balance in such account as of such time (after the application of section 902(b) and section 901(f)(3)(C)) exceeds the net balance in the employment security administration account as of the beginning of that fiscal year (including the fiscal year for which the excess is being computed) for which the net balance was higher than as of the beginning of any other such fiscal year.

(B) With respect to the fiscal years ending June 30, 1970, June 30, 1971, and June 30, 1972, the balance in the employment security administration account at the close of each such fiscal year shall not be considered excess but shall be retained in the account for use as provided in paragraph (1) of subsection (c).

(3)(A) The excess determined as provided in paragraph (2) as of the close of any fiscal year after June 30, 1972, shall be retained (as of the beginning of the succeeding fiscal year) in the employment security administration account until the amount in such account is equal to 40 percent of the amount of the total appropriation by the

Congress out of the employment security administration account for the fiscal year for which the excess is determined. Three-eighths of the amount in the employment security administration account as of the beginning of any fiscal year after June 30, 1972, or $150 million, whichever is the lesser, is authorized to be made available for such fiscal year pursuant to subsection (c)(1) for additional costs of administration due to an increase in the rate of insured unemployment for a calendar quarter of at least 15 percent over the rate of insured unemployment for the corresponding calendar quarter in the immediately preceding year.

(B) If the entire amount of the excess determined as provided in paragraph (2) as of the close of any fiscal year after June 30, 1972, is not retained in the employment security administration account, there shall be transferred (as of the beginning of the succeeding fiscal year) to the extended unemployment compensation account the balance of such excess or so much thereof as is required to increase the amount in the extended unemployment compensation account to the limit provided in section 905(b)(2).

(C) If as of the close of any fiscal year after June 30, 1972, the amount in the extended unemployment compensation account exceeds the limit provided in section 905(b)(2), such excess shall be transferred to the employment security administration account as of the close of such fiscal year.

(4) For the purposes of this section, the net balance in the employment security administration account as of any time is the amount in such account as of such time reduced by the sum of—

(A) the amounts then subject to transfer pursuant to subsection (d), and

(B) the balance of advances (plus interest accrued thereon) then repayable to the revolving fund established by subsection (e).

The net balance in the employment security administration account as of the beginning of any fiscal year shall be determined after the disposition of the excess in such account as of the close of the preceding fiscal year.

Transfers For Calendar Years 1988, 1989, and 1990

(g)(1) With respect to calendar years 1988, 1989, and 1990, the Secretary of the Treasury shall transfer from the employment security administration account—

(A) to the Federal unemployment account an amount equal to 50 percent of the amount of tax received under section 3301(1) of the Federal Unemployment Tax Act which is attributable to the difference in the tax rates between paragraphs (1) and (2) of such section; and

(B) to the extended unemployment compensation account an amount equal to 50 percent of such amount of tax received.

(2) Transfers under this subsection shall be as of the beginning of the month succeeding the month in which the moneys were credited to the employment security administration account pursuant to subsection (b)(2) with respect to wages paid during such calendar years.

TRANSFERS TO FEDERAL UNEMPLOYMENT ACCOUNT AND REPORT TO CONGRESS

TRANSFERS TO FEDERAL UNEMPLOYMENT ACCOUNT

SEC. 902. [42 U.S.C. 1102] (a) Whenever the Secretary of the Treasury determines pursuant to section 901(f) that there is an excess in the employment security administration account as of the close of any fiscal year and the entire amount of such excess is not retained in the employment security administration account or transferred to the extended unemployment compensation account as provided in section 901(f)(3), there shall be transferred (as of the beginning of the succeeding fiscal year) to the Federal unemployment account the balance of such excess or so much thereof as is required to increase the amount in the Federal unemployment account to whichever of the following is the greater:

(1) $550 million, or

(2) the amount (determined by the Secretary of Labor and certified by him to the Secretary of the Treasury) equal to five-eighths of 1 percent of the total wages subject (determined without any limitation on amount) to contributions under all State unemployment compensation laws for the calendar year ending during the fiscal year for which the excess is determined.

Transfers to Employment Security Administration Account[6]

(b) The amount, if any, by which the amount in the Federal unemployment account as of the close of any fiscal year exceeds the greater of the amounts specified in paragraphs (1) and (2) of subsection (a) shall be transferred to the employment security administration account as of the close of such fiscal year.

REPORT TO THE CONGRESS

(c) Whenever the Secretary of Labor has reason to believe that in the next fiscal year the employment security administration account will reach the limit provided for such account in section 901(f)(3)(A), and the Federal unemployment account will reach the limit provided for such account in section 902(a), and the extended unemployment compensation account will reach the limit provided for such account in section 905(b)(2), he shall, after consultation with the Secretary of the Treasury, so report to the Congress with a recommendation for appropriate action by the Congress.

AMOUNTS TRANSFERRED TO STATE ACCOUNTS

In General

SEC. 903. [42 U.S.C. 1103] (a)(1) If as of the close of any fiscal year after the fiscal year ending June 30, 1972, the amount in the extended unemployment compensation account has reached the limit provided in section 905(b)(2) and the amount in the Federal unemployment account has reached the limit provided in section 902(a) and all advances and interest pursuant to section 905(d) and section

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[6] As in original. [P.L. 86-778, §521; 74 Stat. 974.]

1203 have been repaid, and there remains in the employment security administration account any amount over the amount provided in section 901(f)(3)(A), such excess amount, except as provided in subsection (b), shall be transferred (as of the beginning of the succeeding fiscal year) to the accounts of the States in the Unemployment Trust Fund.

(2) Each State's share of the funds to be transferred under this subsection as of any October 1—

(A) shall be determined by the Secretary of Labor and certified by such Secretary to the Secretary of the Treasury before such date, and

(B) shall bear the same ratio to the total amount to be so transferred as—

(i) the amount of wages subject to tax under section 3301 of the Internal Revenue Code of 1986 during the preceding calendar year which are determined by the Secretary of Labor to be attributable to the State, bears to

(ii) the total amount of wages subject to such tax during such year.[7]

Limitations on Transfers

(b)(1) If the Secretary of Labor finds that on October 1 of any fiscal year—

(A) a State is not eligible for certification under section 303, or

(B) the law of a State is not approvable under section 3304 of the Federal Unemployment Tax Act,

then the amount available for transfer to such State's account shall, in lieu of being so transferred, be transferred to the Federal unemployment account as of the beginning of such October 1. If, during the fiscal year beginning on such October 1, the Secretary of Labor finds and certifies to the Secretary of the Treasury that such State is eligible for certification under section 303, that the law of such State is approvable under such section 3304, or both, the Secretary of the Treasury shall transfer such amount from the Federal unemployment account to the account of such State. If the Secretary of Labor does not so find and certify to the Secretary of the Treasury before the close of such fiscal year then the amount which was available for transfer to such State's account as of October 1 of such fiscal year shall (as of the close of such fiscal year) become unrestricted as to use as part of the Federal unemployment account.

(2) The amount which, but for this paragraph, would be transferred to the account of a State under subsection (a) or paragraph (1) of this subsection shall be reduced (but not below zero) by the balance of advances made to the State under section 1201. The sum by which such amount is reduced shall—

(A) be transferred to or retained in (as the case may be) the Federal unemployment account, and

(B) be credited against, and operate to reduce—

(i) first, any balance of advances made before the date of the enactment of the Employment Security Act of 1960[8] to the State under section 1201, and

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[7] P.L. 101-508, §5021(a), amended paragraph (2) in its entirety, applicable to fiscal years beginning after November 5, 1990. [For paragraph (2) as it formerly read, see Vol. III, P.L. 101-508.]

[8] Enacted on September 13, 1960, [Title V of P.L. 86-778; 74 Stat. 970].

(ii) second, any balance of advances made on or after such date to the State under section 1201.

Use of Transferred Amounts

(c)(1) Except as provided in paragraph (2), amounts transferred to the account of a State pursuant to subsections (a) and (b) shall be used only in the payment of cash benefits to individuals with respect to their unemployment, exclusive of expenses of administration.

(2) A State may, pursuant to a specific appropriation made by the legislative body of the State, use money withdrawn from its account in the payment of expenses incurred by it for the administration of its unemployment compensation law and public employment offices if and only if—

(A) the purposes and amounts were specified in the law making the appropriation,

(B) the appropriation law did not authorize the obligation of such money after the close of the two-year period which began on the date of enactment of the appropriation law,

(C) the money is withdrawn and the expenses are incurred after such date of enactment,[9]

(D)(i) the appropriation law limits the total amount which may be obligated under such appropriation at any time to an amount which does not exceed, at any such time, the amount by which—

(I) the aggregate of the amounts transferred to the account of such State pursuant to subsections (a) and (b), exceeds

(II) the aggregate of the amounts used by the State pursuant to this subsection and charged against the amounts transferred to the account of such State, and

(ii) for purposes of clause (i), amounts used by a State for administration shall be chargeable against transferred amounts at the exact time the obligation is entered into, and[10]

(E) the use of the money is accounted for in accordance with standards established by the Secretary of Labor.[11]

(3)(A) If—

(i) amounts transferred to the account of a State pursuant to subsections (a) and (b) of this section were used in payment of unemployment benefits to individuals; and

(ii) the Governor of such State submits a request to the Secretary of Labor that such amounts be restored under this paragraph,

then the amounts described in clause (i) shall be restored to the status of funds transferred under subsections (a) and (b) of this section which have not been used by eliminating any charge against amounts so transferred for the use of such amounts in the payment of unemployment benefits.

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[9] P.L. 101-508, §5021(b)(1), struck out "and".

[10] P.L. 101-508, §5021(b)(2), struck out subparagraph (D) and substituted this subparagraph (D), applicable to fiscal years beginning after November 5, 1990. [For subparagraph (D) as it formerly read, see Vol. III, P.L. 101-508.]

[11] P.L. 101-508, §5021(b)(2), struck out "For the purposes of subparagraph (D), amounts used by a State during any twelve-month period or transitional period of less than twelve months shall be charged against equivalent amounts which were transferred and which have not previously been so charged; except that no amount obligated for administration during any such period may be charged against any amount transferred during a twelve-month period or transitional period of less than twelve months earlier than the thirty-fourth preceding twelve-month period (including the transitional period of less than twelve months if it is within such thirty-four twelve-month periods).", and substituted subparagraph (E), applicable to fiscal years beginning after November 5, 1990.

(B) Subparagraph (A) shall apply only to the extent that the amounts described in clause (i) of such subparagraph do not exceed the amount then in the State's account.

(C) Subparagraph (A) shall not apply if the State has a balance of advances made to its account under title XII of this Act.

(D) If the Secretary of Labor determines that the requirements of this paragraph are met with respect to any request, the Secretary shall notify the Governor of the State that such requirements are met with respect to such request and the amount restored under this paragraph. Such restoration shall be as of the first day of the first month following the month in which the notification is made.

UNEMPLOYMENT TRUST FUND

Establishment, etc.

Sec. 904. [42 U.S.C. 1104] (a) There is hereby established in the Treasury of the United States a trust fund to be known as the "Unemployment Trust Fund", hereinafter in this title called the "Fund". The Secretary of the Treasury is authorized and directed to receive and hold in the Fund all moneys deposited therein by a State agency from a State unemployment fund, or by the Railroad Retirement Board to the credit of the railroad unemployment insurance account or the railroad unemployment insurance administration fund, or otherwise deposited in or credited to the Fund or any account therein. Such deposit may be made directly with the Secretary of the Treasury, with any depositary[12] designated by him for such purpose, or with any Federal Reserve Bank.

Investments

(b) It shall be the duty of the Secretary of the Treasury to invest such portion of the Fund as is not, in his judgment, required to meet current withdrawals. Such investment may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31, United States Code, are hereby extended to authorize the issuance at par of special obligations exclusively to the Fund. Such special obligations shall bear interest at a rate equal to the average rate of interest, computed as of the end of the calendar month next preceding the date of such issue, borne by all interest-bearing obligations of the United States then forming part of the public debt; except that where such average rate is not a multiple of one-eighth of 1 per centum, the rate of interest of such special obligations shall be the multiple of one-eighth of 1 per centum next lower than such average rate. Obligations other than such special obligations may be acquired for the Fund only on such terms as to provide an investment yield not less than the yield which would be required in the case of special obligations if issued to the Fund upon the date of such acquisition. Advances made to the Federal unemployment account pursuant to section 1203 shall not be invested.[13]

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[12] As in original. Possibly should be "depository".

Sale or Redemption of Obligations

(c) Any obligations acquired by the Fund (except special obligations issued exclusively to the Fund) may be sold at the market price, and such special obligations may be redeemed at par plus accrued interest.

Treatment of Interest and Proceeds

(d) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Fund shall be credited to and form a part of the Fund.

Separate Book Accounts

(e) The Fund shall be invested as a single fund, but the Secretary of the Treasury shall maintain a separate book account for each State agency, the employment security administration account, the Federal unemployment account, the railroad unemployment insurance account, and the railroad unemployment insurance administration fund and shall credit quarterly (on March 31, June 30, September 30, and December 31, of each year) to each account, on the basis of the average daily balance of such account, a proportionate part of the earnings of the Fund for the quarter ending on such date. For the purpose of this subsection, the average daily balance shall be computed—

(1) in the case of any State account, by reducing (but not below zero) the amount in the account by the balance of advances made to the State under section 1201, and

(2) in the case of the Federal unemployment account—

(A) by adding to the amount in the account the aggregate of the reductions under paragraph (1), and

(B) by subtracting from the sum so obtained the balance of advances made under section 1203 to the account.

Payments to State Agencies and Railroad Retirement Board

(f) The Secretary of the Treasury is authorized and directed to pay out of the Fund to any State agency such amount as it may duly requisition, not exceeding the amount standing to the account of such State agency at the time of such payment. The Secretary of the Treasury is authorized and directed to make such payments out of the railroad unemployment insurance account for the payment of benefits, and out of the railroad unemployment insurance administration fund for the payment of administrative expenses, as the Railroad Retirement Board may duly certify, not exceeding the amount standing to the credit of such account or such fund, as the case may be, at the time of such payment.

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[13] See Vol. II, P.L. 100-203, §9401, with respect to the restoration of trust funds for 1987.

Federal Unemployment Account

(g) There is hereby established in the Unemployment Trust Fund a Federal unemployment account. There is hereby authorized to be appropriated to such Federal unemployment account a sum equal to (1) the excess of taxes collected prior to July 1, 1946, under title IX of this Act or under the Federal Unemployment Tax Act, over the total unemployment administrative expenditures made prior to July 1, 1946, plus (2) the excess of taxes collected under the Federal Unemployment Tax Act after June 30, 1946, and prior to July 1, 1953, over the unemployment administrative expenditures made after June 30, 1946, and prior to July 1, 1953. As used in this subsection, the term "unemployment administrative expenditures" means expenditures for grants under title III of this Act, expenditures for the administration of that title by the Social Security Board, the Federal Security Administrator, or the Secretary of Labor, and expenditures for the administration of title IX of this Act, or of the Federal Unemployment Tax Act, by the Department of the Treasury, the Social Security Board, the Federal Security Administrator, or the Secretary of Labor. For the purposes of this subsection, there shall be deducted from the total amount of taxes collected prior to July 1, 1943, under title IX of this Act, the sum of $40,561,886.43 which was authorized to be appropriated by the Act of August 24, 1937[14] (50 Stat. 754), and the sum of $18,451,846 which was authorized to be appropriated by section 11(b) of the Railroad Unemployment Insurance Act[15].

EXTENDED UNEMPLOYMENT COMPENSATION ACCOUNT[16]

ESTABLISHMENT OF ACCOUNT

SEC. 905. [42 U.S.C. 1105] (a) There is hereby established in the Unemployment Trust Fund an extended unemployment compensation account. For the purposes provided for in section 904(e), such account shall be maintained as a separate book account.

TRANSFERS TO ACCOUNT

(b)(1) Except as provided by paragraph (3), the Secretary of the Treasury shall transfer (as of the close of July 1970, and each month thereafter), from the employment security administration account to the extended unemployment compensation account established by subsection (a), an amount determined by him to be equal, in the case of any month before April 1972, to one-fifth, and in the case of any month after March 1972, to one-tenth, of the amount by which—

(A) transfers to the employment security administration account pursuant to section 901(b)(2) during such month, exceed

(B) payments during such month from the employment security administration account pursuant to section 901(b)(3) and (d).

If for any such month the payments referred to in subparagraph (B) exceed the transfers referred to in subparagraph (A), proper adjustments shall be made in the amounts subsequently transferred.

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[14] P.L. 75-353.

[15] P.L. 75-722.

[16] See Vol. II, P.L. 97-248, §604(a), with respect to an appropriation of funds to assist States in meeting administrative costs.

(2) Whenever the Secretary of the Treasury determines pursuant to section 901(f) that there is an excess in the employment security administration account as of the close of any fiscal year beginning after June 30, 1972, there shall be transferred (as of the beginning of the succeeding fiscal year) to the extended unemployment compensation account the total amount of such excess or so much thereof as is required to increase the amount in the extended unemployment compensation account to whichever of the following is the greater:

(A) $750,000,000, or

(B) the amount (determined by the Secretary of Labor and certified by him to the Secretary of the Treasury) equal to three-eighths of 1 percent of the total wages subject (determined without any limitation on amount) to contributions under all State unemployment compensation laws for the calendar year ending during the fiscal year for which the excess is determined.

(3) The Secretary of the Treasury shall make no transfer pursuant to paragraph (1) as of the close of any month if he determines that the amount in the extended unemployment compensation account is equal to (or in excess of) the limitation provided in paragraph (2).

TRANSFERS TO STATE ACCOUNTS

(c) Amounts in the extended unemployment compensation account shall be available for transfer to the accounts of the States in the Unemployment Trust Fund as provided in section 204(e) of the Federal-State Extended Unemployment Compensation Act of 1970[17].

ADVANCES TO EXTENDED UNEMPLOYMENT COMPENSATION ACCOUNT AND REPAYMENT

(d) There are hereby authorized to be appropriated, without fiscal year limitation, to the extended unemployment compensation account, as repayable advances, such sums as may be necessary to carry out the purposes of the Federal-State Extended Unemployment Compensation Act of 1970. Amounts appropriated as repayable advances shall be repaid by transfers from the extended unemployment compensation account to the general fund of the Treasury, at such times as the amount in the extended unemployment compensation account is determined by the Secretary of the Treasury, in consultation with the Secretary of Labor, to be adequate for such purpose. Repayments under the preceding sentence shall be made whenever the Secretary of the Treasury (after consultation with the Secretary of Labor) determines that the amount then in the account exceeds the amount necessary to meet the anticipated payments from the account during the next 3 months. Any amount transferred as a repayment under this subsection shall be credited against, and shall operate to reduce, any balance of advances repayable under this subsection. Amounts appropriated as repayable advances for purposes of this subsection shall bear interest at a rate equal to the average rate of interest, computed as of the end of the calendar month next preceding the date of such advance, borne by all interest bearing obligations of the United States then forming part of the public debt; except that in cases in which such average rate is not a multiple of one-eighth of 1 percent, the rate of interest shall be the multiple of one-eighth of 1 percent next lower than such average rate.

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[17] P.L. 91-373.

UNEMPLOYMENT COMPENSATION RESEARCH PROGRAM

SEC. 906. [42 U.S.C. 1106] (a) The Secretary of Labor shall—

(1) establish a continuing and comprehensive program of research to evaluate the unemployment compensation system. Such research shall include, but not be limited to, a program of factual studies covering the role of unemployment compensation under varying patterns of unemployment including those in seasonal industries, the relationship between the unemployment compensation and other social insurance programs, the effect of State eligibility and disqualification provisions, the personal characteristics, family situations, employment background and experience of claimants, with the results of such studies to be made public; and

(2) establish a program of research to develop information (which shall be made public) as to the effect and impact of extending coverage to excluded groups with first attention to agricultural labor.

(b) To assist in the establishment and provide for the continuation of the comprehensive research program relating to the unemployment compensation system, there are hereby authorized to be appropriated for the fiscal year ending June 30, 1971, and for each fiscal year thereafter, such sums, not to exceed $8,000,000, as may be necessary to carry out the purposes of this section. From the sums authorized to be appropriated by this subsection the Secretary may provide for the conduct of such research through grants or contracts.

PERSONNEL TRAINING

SEC. 907. [42 U.S.C. 1107] (a) In order to assist in increasing the effectiveness and efficiency of administration of the unemployment compensation program by increasing the number of adequately trained personnel, the Secretary of Labor shall—

(1) provide directly, through State agencies, or through contracts with institutions of higher education or other qualified agencies, organizations, or institutions, programs and courses designed to train individuals to prepare them, or improve their qualifications, for service in the administration of the unemployment compensation program, including claims determinations and adjudication, with such stipends and allowances as may be permitted under regulations of the Secretary;

(2) develop training materials for and provide technical assistance to the State agencies in the operation of their training programs;

(3) under such regulations as he may prescribe, award fellowships and traineeships to persons in the Federal-State employment security agencies, in order to prepare them or improve their qualifications for service in the administration of the unemployment compensation program.

(b) The Secretary may, to the extent that he finds such action to be necessary, prescribe requirements to assure that any person receiving a fellowship, traineeship, stipend or allowance shall repay the costs thereof to the extent that such person fails to serve in the Federal-State employment security program for the period prescribed by the Secretary. The Secretary may relieve any individual of his obligation to so repay, in whole or in part, whenever and to the extent that such repayment would, in his judgment, be inequitable or would be contrary to the purposes of any of the programs established by this section.

(c) The Secretary, with the concurrence of the State, may detail Federal employees to State unemployment compensation administration and the Secretary may concur in the detailing of State employees to the United States Department of Labor for temporary periods for training or for purposes of unemployment compensation administration, and the provisions of section 507 of the Elementary and Secondary Education Act of 1965[18] (79 Stat. 27) or any more general program of interchange enacted by a law amending, supplementing, or replacing section 507 shall apply to any such assignment.

(d) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1971, and for each fiscal year thereafter such sums, not to exceed $5,000,000, as may be necessary to carry out the purposes of this section.

FEDERAL ADVISORY COUNCIL

Sec. 908. [42 U.S.C. 1108] (a) The Secretary of Labor shall establish a Federal Advisory Council, of not to exceed 16 members including the chairman, for the purpose of reviewing the Federal-State program of unemployment compensation and making recommendations to him for improvement of the system.

(b) The Council shall be appointed by the Secretary without regard to the civil service laws and shall consist of men and women who shall be representatives of employers and employees in equal numbers, and the public.

(c) The Secretary may make available to the Council an Executive Secretary and secretarial, clerical, and other assistance, and such pertinent data prepared by the Department of Labor, as it may require to carry out its functions.

(d) Members of the Council shall, while serving on business of the Council, be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including travel time; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by 5 U.S.C. 5703 for persons in government service employed intermittently.

(e) The Secretary shall encourage the organization of similar State advisory councils.

(f) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1971, and for each fiscal year thereafter such sums, not to exceed $100,000, as may be necessary to carry out the purposes of this section.

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[18] See, instead, Vol. II, 5 U.S.C. 3371-3376. [P.L. 89-10, 79 Stat. 27, §507 was classified to 20 U.S.C. 867. P.L. 91-230, §143(a)(3), redesignated §507 as §553; §553 was classified to 20 U.S.C. 869b. P.L. 91-648, 81 Stat. 1909, §403, repealed §553, effective January 5, 1971. P.L. 91-648, §402, approved January 5, 1971, amended chapter 33 of Title 5, U.S.C., to include 5 U.S.C. 3371-3376, "Subchapter VI, Assignments to and from States".]

FEDERAL EMPLOYEES COMPENSATION ACCOUNT[19]

SEC. 909. [42 U.S.C. 1109] There is hereby established in the Unemployment Trust Fund a Federal Employees Compensation Account which shall be used for the purposes specified in section 8509 of title 5, United States Code. For the purposes provided for in section 904(e), such account shall be maintained as a separate book account.

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[19] See Vol. II, P.L. 97-362, §202(b)(2), with respect to the treatment of previously appropriated funds.

[TITLE X—GRANTS TO STATES FOR AID TO THE BLIND][1]

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APPROPRIATION

SECTION 1001. [42 U.S.C. 1201] For the purpose of enabling each State to furnish financial assistance, as far as practicable under the conditions in such State, to needy individuals who are blind, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for aid to the blind.

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[1] P.L. 92-603, §303, *repealed* Title X, effective January 1, 1974, *except* with respect to Puerto Rico, Guam, and the Virgin Islands.

Title X of the Social Security Act is administered by the Department of Health and Human Services (formerly the Department of Health, Education, and Welfare). The Office of Family Assistance, Social Security Administration, administers benefit payments under Title X. The Administration for Public Services, Office of Human Development Services, administers social services under Title X.

Title X appears in the United States Code as §§1201-1206, subchapter X, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services relating to Title X are contained in subtitle A and chapter XIII, Title 45, Code of Federal Regulations.

The Commonwealth of the Northern Marianas may elect to initiate a Title X social services program if it chooses; see P.L. 94-241, [Covenant to Establish Northern Mariana Islands], approved March 24, 1976.

See Vol. II, 31 U.S.C. 6504-6505 with respect to intergovernmental cooperation.

See Vol. II, 31 U.S.C. 7501-7507 with respect to uniform audit requirements for State and local governments receiving Federal financial assistance.

See Vol. II, P.L. 82-183, §618, for the "Jenner Amendment", which prohibits denial of grants-in-aid under certain conditions.

See Vol. II, P.L. 88-352, §601, for prohibition against discrimination in federally assisted programs.

See Vol. II, P.L. 89-97, §121(b), with respect to restrictions on payment to a State receiving payments under Title XIX.

See Vol. II, P.L. 95-521, §102(i), with respect to reporting of benefits received under the Social Security Act.

[2] This table of contents does not appear in the law.

STATE PLANS FOR AID TO THE BLIND

Sec. 1002. [42 U.S.C. 1202] (a) A State plan for aid to the blind must (1) except to the extent permitted by the Secretary with respect to services, provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them; (2) provide for financial participation by the State; (3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan; (4) provide (A) for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid to the blind is denied or is not acted upon with reasonable promptness, and (B) that if the State plan is administered in each of the political subdivisions of the State by a local agency and such local agency provides a hearing at which evidence may be presented prior to a hearing before the State agency, such local agency may put into effect immediately upon issuance its decision upon the matter considered at such hearing; (5) provide (A) such methods of administration (including after January 1, 1940, methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan[3], and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low-income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency; (6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports; and (7) provide that no aid will be furnished any individual under the plan with respect to any period with respect to which he is receiving old-age assistance under the State plan approved under section 2 of this Act or aid to families with dependent children under the State plan approved under section 402 of this Act; (8) provide that the State agency shall, in determining need, take into consideration any other income and resources of the individual claiming aid to the blind, as well as any expenses reasonably attributable to the earning of any such income, except that, in making such determination, the State agency (A) shall disregard the first $85 per month of earned income, plus one-half of earned income in excess of $85 per month, (B) shall, for a period not in excess of twelve months, and may, for a period not in excess of thirty-six months, disregard such additional amounts of other income and resources, in the case of an individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan, and (C) may, before disregarding the amounts referred to in clauses (A) and (B), disregard not more than $7.50 of any income;[4] (9) provide safeguards which permit the use or disclosure of information concerning applicants or recipients only (A) to public officials who require such information in connection with their official duties, or (B) to other persons for purposes directly connected with the administration of the State plan;[5] (10) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select; (11) effective July 1, 1951, provide that all individuals wishing to make application for aid to the blind shall have opportunity to do so, and that aid to the blind shall be furnished with reasonable promptness to all eligible individuals; (12) effective July 1, 1953, provide, if the plan includes payments to individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions; (13) provide a description of the services (if any) which the State agency makes available (using whatever internal organizational arrangement it finds appropriate for this purpose) to applicants for and recipients of aid to the blind to help them attain self-support or self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services; and (14) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act.

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[3] P.L. 91-648, §208(a)(3)(D), transferred to the U.S. Civil Service Commission, effective March 6, 1971, all powers, functions, and duties of the Secretary under subparagraph (A).

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[4] See Vol. II, 10 U.S.C. 2546 with respect to shelter for the homeless at military installations.

See Vol. II, P.L. 79-396, §12(e), with respect to exclusion from income and resources of assistance to children under that act.

See Vol. II, P.L. 81-171, §521(a)(1)(E), with respect to exclusion from income and resources of certain assistance rendered to provide occupant-owned, rental and cooperative housing.

See Vol. II, P.L. 87-543, §141(b), with respect to ineligibility to receive payments under Title X where payments have been made under Title XVI.

See Vol. II, P.L. 88-352, §601, for prohibition against discrimination in federally assisted programs.

See Vol. II, P.L. 88-525, §8(b), with respect to exclusion from income and resources of the value of food stamps.

See Vol. II, P.L. 89-73, §210(b), with respect to exclusion from income of the costs of any project under that act.

See Vol. II, P.L. 89-329, §479B, with respect to exclusion from income or resources of certain student financial assistance.

See Vol. II, P.L. 89-642, §11(b), with respect to exclusion from income and resources of the value of assistance to children under that act.

See Vol. II, P.L. 90-248, §248(c), effective July 1, 1969, with respect to income disregards applicable to Guam, Puerto Rico, and the Virgin Islands.

See Vol. II, P.L. 91-646, §216, with respect to exclusion from income of payments made under that act.

See Vol. II, P.L. 93-112, §613(c), with respect to conditional exclusion of wages, allowances, transportation reimbursement, and attendant care costs.

See Vol. II, P.L. 93-113, §404(g), with respect to exclusion from income and resources of payments to volunteers under that act.

See Vol. II, P.L. 93-134, §§7 and 8, with respect to exclusion from income and resources of certain judgment funds to any Indian tribe.

See Vol. II, P.L. 93-288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 94-114, §6, with respect to exclusion from income and resources of property and receipts from submarginal land to certain Indians.

See Vol. II, P.L. 95-433, §2, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 95-498, §6, with respect to an income and resources exclusion applicable to the Pueblo of Santa Ana Indians, New Mexico.

See Vol. II, P.L. 95-499, §6, with respect to an income and resources exclusion applicable to the Pueblo of Zia Indians, New Mexico.

See Vol. II, P.L. 95-557, §410(b), with respect to exclusion from income of services (but not of wages) provided to a public housing resident or to a resident of a housing project assisted under the "Housing Act of 1959" (see Vol. II, P.L. 86-372, §202.).

See Vol. II, P.L. 97-35, §2605(f), with respect to exclusion from income and resources of home energy assistance payments or allowances.

See Vol. II, P.L. 98-64, §2(a), with respect to exclusion from income and resources of per capita payments to Indians.

See Vol. II, P.L. 98-432, §5(e), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98-500, §8, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98-602, §106(d), with respect to exclusion from income and resources of certain funds distributed per capita.

See Vol. II, P.L. 99-130, §8, with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99-146, §6(b), with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99-264, §16, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99-346, §6(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99-377, §4(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 100-139, §4(h)(6), with respect to exclusion of benefits as basis for denial of eligibility.

See Vol. II, P.L. 100-407, §105(c), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100-409, §5, with respect to the effect of this Act on P.L. 92-203 or P.L. 96-487.

See Vol. II, P.L. 100-411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100-581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 101-41, §10(b)-(d), with respect to eligibility for Federal programs and treatment of funds, assets, and income.

See Vol. II, P.L. 101-42, §3, with respect to the restoration of Federal recognition, rights, and privileges.

See Vol. II, P.L. 101-201, with respect to Agent Orange settlement payments.

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for aid to the blind under the plan—

(1) Any residence requirement which excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for aid and has resided therein continuously for one year immediately preceding the application; or

(2) Any citizenship requirement which excludes any citizen of the United States.

At the option of the State, the plan may provide that manuals and other policy issuances will be furnished to persons without charge for the reasonable cost of such materials, but such provision shall not be required by the Secretary as a condition for the approval of such plan under this title. In the case of any State (other than Puerto Rico and the Virgin Islands) which did not have on January 1, 1949, a State plan for aid to the blind approved under this title, the Secretary shall approve a plan of such State for aid to the blind for purposes of this title, even though it does not meet the requirements of clause (8) of subsection (a) of this section, if it meets all other requirements of this title for an approved plan for aid to the blind; but payments under section 1003 shall be made, in the case of any such plan, only with respect to expenditures thereunder which would

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See Vol. II, P.L. 101-239, §10405, with respect to Agent Orange settlement payments excluded from countable income and resources under Federal means-tested programs.

See Vol. II, P.L. 101-277, §8(b), with respect to exclusion, from income or resources, of funds held in trust or distributed to Seminole Indians.

[5] See Vol. II, P.L. 82-183, §618, for the "Jenner Amendment" prohibiting denial of grants-in-aid under certain conditions.

be included as expenditures for the purposes of section 1003 under a plan approved under this section without regard to the provisions of this sentence.

PAYMENT TO STATES

Sec. 1003. [42 U.S.C. 1203] (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid to the blind, for each quarter, beginning with the quarter commencing October 1, 1958—

[(1) Stricken.[6]]

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as aid to the blind under the State plan, not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of aid to the blind for such month; and

(3) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and efficient administration of the State plan—

(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

(B) 100 percent of so much of such expenditures as are for the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus

(C) one-half of the remainder of such expenditures.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Health, Education, and Welfare shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of blind individuals in the State, and (C) such other investigation as the Secretary may find necessary.

(2) The Secretary of Health, Education, and Welfare shall then certify to the Secretary of the Treasury the amount so estimated by the Secretary of Health, Education, and Welfare, (A) reduced

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[6] P.L. 97-35, §2184(c)(2)(A); 95 Stat. 817.

or increased, as the case may be, by any sum by which he finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Secretary of Health, Education, and Welfare, of the net amount recovered during a prior quarter by the State or any political subdivision thereof with respect to aid to the blind furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Health, Education, and Welfare for such prior quarter: *Provided,* That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause (B) of this paragraph.

(3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement[7] of the Treasury Department, and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Health, Education, and Welfare, the amounts so certified.

OPERATION OF STATE PLANS

SEC. 1004. [42 U.S.C. 1204] In the case of any State plan for aid to the blind which has been approved by the Secretary of Health, Education, and Welfare, if the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds—

(1) that the plan has been so changed as to impose any residence or citizenship requirement prohibited by section 1002(b), or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or

(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 1002(a) to be included in the plan;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) until the Secretary is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

ADMINISTRATION

SEC. 1005. [42 U.S.C. 1205] There is hereby authorized to be appropriated for the fiscal year ending June 30, 1936, the sum of $30,000, for all necessary expenses of the Board in administering the provisions of this title.

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[7] As in original.

DEFINITION

SEC. 1006. [42 U.S.C. 1206] For the purposes of this title, the term "aid to the blind" means money payments to blind individuals who are needy, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases. Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1002 includes provision for—

(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the blind to be paid (and in conjunction with other income and resources), meet all the need[8] of the individuals with respect to whom such payments are made;

(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made.

At the option of a State (if its plan approved under this title so provides), such term (i) need not include money payments to an individual who has been absent from such State for a period in excess of 90 consecutive days (regardless of whether he has maintained his residence in such State during such period) until he has been present in such State for 30 consecutive days in the case of such an individual who has maintained his residence in such State during such period or 90 consecutive days in the case of any other such individual, and (ii) may include rent payments made directly to a public housing agency on behalf of a recipient or a group or groups of recipients of aid under such plan.

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[8] As in original. Should be "needs".

TITLE XI—GENERAL PROVISIONS AND PEER REVIEW[1]

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[1] Title XI of the Social Security Act is administered by the Department of Health and Human Services (formerly the Department of Health, Education, and Welfare) and by the Department of Labor.

Title XI appears in the United States Code as §§1301-1320c-13, subchapter XI, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services relating to Title XI are contained in chapter III, Title 20, in chapters I, II, and IV, Title 42, and in subtitle A and chapters I, III, and XIII, Title 45, Code of Federal Regulations. Regulations of the Secretary of Labor relating to Title XI are contained in chapter V, Title 20, and subtitle A, Title 29, Code of Federal Regulations.

See Vol. II, P.L. 88-164, §124(b)(4), with respect to the membership of the State Planning Councils.

See Vol. II, P.L. 88-352, §601, for prohibition against discrimination in federally assisted programs.

See Vol. II, P.L. 100-204, §724(d), with respect to furnishing information to the United States Commission on Improving the Effectiveness of the United Nations; and §725(b), with respect to the detailing of Government personnel.

See Vol. II, P.L. 100-235, §§5-8, with respect to responsibilities of each Federal agency for computer systems security and privacy.

See Vol. II, P.L. 101-508, §5108, with respect to demonstration projects relating to accountability for telephone service center communications; §5110, with respect to telephone access to the Social Security Administration; and §5120(a)-(e), with respect to vocational rehabilitation demonstration projects.

[2] This table of contents does not appear in the law.

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PART A—GENERAL PROVISIONS

DEFINITIONS

SEC. 1101. [42 U.S.C. 1301] (a) When used in this Act—

(1) The term "State", except where otherwise provided, includes the District of Columbia and the Commonwealth of Puerto Rico, and when used in titles IV, V, VII, XI, and XIX includes the Virgin Islands and Guam. Such term when used in titles III, IX, and XII also includes the Virgin Islands. Such term when used in title V and in part B of this title also includes American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands. Such term when used in title XIX also includes the Northern Mariana Islands and American Samoa. In the case of Puerto Rico, the Virgin Islands, and Guam, titles I, X, and XIV, and title XVI (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972[3]) shall continue to apply, and the term "State" when used in such titles (but not in title XVI as in effect pursuant to such amendment after December 31, 1973) includes Puerto Rico, the Virgin Islands, and Guam. Such term when used in title XX also includes the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Such term when used in title IV also includes American Samoa.

(2) The term "United States" when used in a geographical sense means, except where otherwise provided, the States.

(3) The term "person" means an individual, a trust or estate, a partnership, or a corporation.

(4) The term "corporation" includes associations, joint-stock companies, and insurance companies.

(5) The term "shareholder" includes a member in an association, joint-stock company, or insurance company.

(6) The term "Secretary", except when the context otherwise requires, means the Secretary of Health and Human Services.

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[3] P.L. 92-603, §301, added Title XVI, Supplemental Security Income for the Aged, Blind, and Disabled.

(7) The terms "physician" and "medical care" and "hospitalization" include osteopathic practitioners or the services of osteopathic practitioners and hospitals within the scope of their practice as defined by State law.

(8)(A) The "Federal percentage" for any State (other than Puerto Rico, the Virgin Islands, and Guam) shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 50 per centum as the square of the per capita income of such State bears to the square of the per capita income of the United States; except that the Federal percentage shall in no case be less than 50 per centum or more than 65 per centum.

(B) The Federal percentage for each State (other than Puerto Rico, the Virgin Islands, and Guam) shall be promulgated by the Secretary between October 1 and November 30 of each year, on the basis of the average per capita income of each State and of the United States for the three most recent calendar years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the four quarters in the period beginning October 1 next succeeding such promulgation: *Provided,* That the Secretary shall promulgate such percentages as soon as possible after the enactment of the Social Security Amendments of 1958[4], which promulgation shall be conclusive for each of the eleven quarters in the period beginning October 1, 1958, and ending with the close of June 30, 1961.

(C) The term "United States" means (but only for purposes of subparagraphs (A) and (B) of this paragraph) the fifty States and the District of Columbia.

(D) Promulgations made before satisfactory data are available from the Department of Commerce for a full year on the per capita income of Alaska shall prescribe a Federal percentage for Alaska of 50 per centum and, for purposes of such promulgations, Alaska shall not be included as part of the "United States". Promulgations made thereafter but before per capita income data for Alaska for a full three-year period are available from the Department of Commerce shall be based on satisfactory data available therefrom for Alaska for such one full year or, when such data are available for a two-year period, for such two years.

(9) The term "shared health facility" means any arrangement whereby—

(A) two or more health care practitioners practice their professions at a common physical location;

(B) such practitioners share (i) common waiting areas, examining rooms, treatment rooms, or other space, (ii) the services of supporting staff, or (iii) equipment;

(C) such practitioners have a person (who may himself be a practitioner)—

(i) who is in charge of, controls, manages, or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at such common physical location, other than the direct furnishing of professional health care services by the practitioners to their patients; or

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[4] August 28, 1958 [P.L. 85-840; 72 Stat. 1013].

(ii) who makes available to such practitioners the services of supporting staff who are not employees of such practitioners;

and who is compensated in whole or in part, for the use of such common physical location or support services pertaining thereto, on a basis related to amounts charged or collected for the services rendered or ordered at such location or on any basis clearly unrelated to the value of the services provided by the person; and

(D) at least one of such practitioners received payments on a fee-for-service basis under titles XVIII and XIX in an amount exceeding $5,000 for any one month during the preceding 12 months or in an aggregate amount exceeding $40,000 during the preceding 12 months;

except that such term does not include a provider of services (as defined in section 1861(u) of this Act), a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act[5]), a hospital cooperative shared services organization meeting the requirements of section 501(e) of the Internal Revenue Code of 1954[6], or any public entity.

(b) The terms "includes" and "including" when used in a definition contained in this Act shall not be deemed to exclude other things otherwise within the meaning of the term defined.

(c) Whenever under this Act or any Act of Congress, or under the law of any State, an employer is required or permitted to deduct any amount from the remuneration of an employee and to pay the amount deducted to the United States, a State, or any political subdivision thereof, then for the purposes of this Act the amount so deducted shall be considered to have been paid to the employee at the time of such deduction.

(d) Nothing in this Act shall be construed as authorizing any Federal official, agent, or representative, in carrying out any of the provisions of this Act, to take charge of any child over the objection of either of the parents of such child, or of the person standing in loco parentis to such child.

RULES AND REGULATIONS[7]

SEC. 1102. [42 U.S.C. 1302] (a) The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, respectively, shall make and publish such rules and regulations, not inconsistent with this Act, as may be necessary to the efficient administration of the functions with which each is charged under this Act.

(b)(1) Whenever the Secretary publishes a general notice of proposed rulemaking for any rule or regulation proposed under title XVIII, title XIX, or part B of this title that may have a significant impact on the operations of a substantial number of small rural hospitals, the Secretary shall prepare and make available for public comment an initial regulatory impact analysis. Such analysis shall describe the impact of the proposed rule or regulation on such hospitals and shall set forth, with respect to small rural hospitals, the matters required under section 603 of title 5, United States Code, to be set forth with respect to small entities. The initial regulatory impact analysis (or a summary) shall be published in the Federal Register at the time of the publication of general notice of proposed rulemaking for the rule or regulation.

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[5] P.L. 78-410.

[6] P.L. 83-591.

P.L. 99-514, §2, provides, except when inappropriate, any reference to the Internal Revenue Code of 1954 shall include a reference to the Internal Revenue Code of 1986.

[7] See Vol. II, P.L. 94-437, §702(b), with respect to regulations applicable to Indians.

(2) Whenever the Secretary promulgates a final version of a rule or regulation with respect to which an initial regulatory impact analysis is required by paragraph (1), the Secretary shall prepare a final regulatory impact analysis with respect to the final version of such rule or regulation. Such analysis shall set forth, with respect to small rural hospitals, the matters required under section 604 of title 5, United States Code, to be set forth with respect to small entities. The Secretary shall make copies of the final regulatory impact analysis available to the public and shall publish, in the Federal Register at the time of publication of the final version of the rule or regulation, a statement describing how a member of the public may obtain a copy of such analysis.

(3) If a regulatory flexibility analysis is required by chapter 6 of title 5, United States Code, for a rule or regulation to which this subsection applies, such analysis shall specifically address the impact of the rule or regulation on small rural hospitals.

SEPARABILITY

SEC. 1103. [42 U.S.C. 1303] If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

RESERVATION OF POWER

SEC. 1104. [42 U.S.C. 1304] The right to alter, amend, or repeal any provision of this Act is hereby reserved to the Congress.

SHORT TITLE

SEC. 1105. [42 U.S.C. 1305] This Act may be cited as the "Social Security Act".

DISCLOSURE OF INFORMATION IN POSSESSION OF AGENCY[8]

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[8] Reorganization Plan No. 2 of 1949 transferred to the Secretary of Labor certain duties and functions of the Federal Security Administrator (now the Secretary of Health and Human Services), with respect to employment services, unemployment compensation, and the Bureau of Employment Security (which was also transferred to the Department of Labor from the Federal Security Administration). Reorganization Plan No. 19 of 1950 transferred the Bureau of Employees' Compensation from the Federal Security Administration (now the Department of Health and Human Services) to the Department of Labor and provided for the transfer from the Federal Security Administrator to the Secretary of Labor of certain functions and duties with respect to the Bureau of Employees' Compensation and with respect to employees' compensation, including workmen's compensation. In effect, with respect to these functions and duties, the provisions of this section of the Social Security Act also apply to the Secretary of Labor.

See Vol. II, 5 U.S.C. 552(b)(3), with respect to certain limitations on §1106.

See Vol. II, 5 U.S.C. 8347(m)(3), with respect to disclosure of information to the Office of Personnel Management.

See Vol. II, 38 U.S.C. §§3117 and 3118, with respect to information obtained from the Secretary.

SEC. 1106. [42 U.S.C. 1306] (a) No disclosure of any return or portion of a return (including information returns and other written statements) filed with the Commissioner of Internal Revenue under title VIII of the Social Security Act or under subchapter E of chapter 1 or subchapter A of chapter 9 of the Internal Revenue Code[9], or under regulations made under authority thereof, which has been transmitted to the Secretary by the Commissioner of Internal Revenue, or of any file, record, report, or other paper, or any information, obtained at any time by the Secretary or by any officer or employee of the Department of Health and Human Services in the course of discharging the duties of the Secretary under this Act, and no disclosure of any such file, record, report, or other paper, or information, obtained at any time by any person from the Secretary or from any officer or employee of the Department of Health and Human Services, shall be made except as the Secretary may by regulations prescribe and except as otherwise provided by Federal law. Any person who shall violate any provision of this section shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not exceeding $1,000, or by imprisonment not exceeding one year, or both.

(b) Requests for information, disclosure of which is authorized by regulations prescribed pursuant to subsection (a) of this section, and requests for services, may, subject to such limitations as may be prescribed by the Secretary to avoid undue interference with his functions under this Act, be complied with if the agency, person, or organization making the request agrees to pay for the information or services requested in such amount, if any (not exceeding the cost of furnishing the information or services), as may be determined by the Secretary. Payments for information or services furnished pursuant to this section shall be made in advance or by way of reimbursement, as may be requested by the Secretary, and shall be deposited in the Treasury as a special deposit to be used to reimburse the appropriations (including authorizations to make expenditures from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust Fund) for the unit or units of the Department of Health and Human Services which furnished the information or services. Notwithstanding the preceding provisions of this subsection, requests for information made pursuant to the provisions of part D of title IV of this Act for the purpose of using Federal records for locating parents shall be complied with and the cost incurred in providing such information shall be paid for as provided in such part D of title IV.[10]

See Vol. II, P.L. 83-591, §6103(l)(1), with respect to disclosure of returns and return information by the Secretary of the Treasury to the Social Security Administration; and §7213(a)(1), with respect to the penalty for unauthorized disclosure of that tax return information.

See Vol. II, P.L. 88-525, §11(e)(19), with respect to requesting and exchanging information for purposes of verifying income and eligibility for food stamps.

See Vol. II, P.L. 97-253, §307(f), with respect to supplying information about civil service annuitants.

See Vol. II, P.L. 101-508, §8051(c), with respect to notices to current beneficiaries.

[9] P.L. 76-1. Should refer, instead, to P.L. 83-591, Subtitles A and C.

[10] 38 U.S.C. 3006 requires all Federal agencies to provide the Veterans' Administration with all information it may require for purposes of administering veterans' programs.

P.L. 94-505, §201, created the Office of Inspector General within the Department of Health and Human Services and sets forth duties and responsibilities, including authority over audits and investigations dealing with Departmental programs and operations, effective October 15, 1976.

(c) Notwithstanding sections 552 and 552a of title 5, United States Code, or any other provision of law, whenever the Secretary determines that a request for information is made in order to assist a party in interest (as defined in section 3 of the Employee Retirement Income Security Act of 1974[11] (29 U.S.C. 1002)) with respect to the administration of an employee benefit plan (as so defined), or is made for any other purpose not directly related to the administration of the program or programs under this Act to which such information relates, the Secretary may require the requester to pay the full cost, as determined by the Secretary, of providing such information.

(d) Notwithstanding any other provision of this section the Secretary shall make available to each State agency operating a program under title XIX and shall, subject to the limitations contained in subsection (e), make available for public inspection in readily accessible form and fashion, the following official reports (not including, however, references to any internal tolerance rules and practices that may be contained therein, internal working papers or other informal memoranda) dealing with the operation of the health programs established by titles XVIII and XIX—

(1) individual contractor performance reviews and other formal evaluations of the performance of carriers, intermediaries, and State agencies, including the reports of follow-up reviews;

(2) comparative evaluations of the performance of such contractors, including comparisons of either overall performance or of any particular aspect of contractor operation; and

(3) program validation survey reports and other formal evaluations of the performance of providers of services, including the reports of follow-up reviews, except that such reports shall not identify individual patients, individual health care practitioners, or other individuals.

(e) No report described in subsection (d) shall be made public by the Secretary or the State title XIX agency until the contractor or provider of services whose performance is being evaluated has had a reasonable opportunity (not exceeding 60 days) to review such report and to offer comments pertinent parts of which may be incorporated in the public report; nor shall the Secretary be required to include in any such report information with respect to any deficiency (or improper practice or procedures) which is known by the Secretary to have been fully corrected, within 60 days of the date such deficiency was first brought to the attention of such contractor or provider of services, as the case may be.

PENALTY FOR FRAUD[12]

SEC. 1107. [42 U.S.C. 1307] (a) Whoever, with the intent to defraud any person, shall make or cause to be made any false representation concerning the requirements of this Act, of chapter 2, 21, or 23 of the Internal Revenue Code of 1954[13], or of any provision of subtitle F of such Code which corresponds (within the meaning of section 7852(b) of such Code) to a provision contained in subchapter E of chapter 9 of the Internal Revenue Code of 1939[14], or of any rules or regulations issued thereunder, knowing such representations to be false, shall be deemed guilty of a misdemeanor, and, upon conviction thereof, shall be punished by a fine not exceeding $1,000, or by imprisonment not exceeding one year, or both.

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[11] P.L. 93-406.

[12] See Vol. II, 18 U.S.C. 1028, 1738, with respect to penalties relating to use of identification documents.

[13] P.L. 83-591.

[14] P.L. 76-1.

(b) Whoever, with the intent to elicit information as to the date of birth, employment, wages, or benefits of any individual (1) falsely represents to the Secretary of Health and Human Services that he is such individual, or the wife, husband, widow, widower, divorced wife, divorced husband, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father, child, or parent of such individual, or the duly authorized agent of such individual, or of the wife, husband, widow, widower, divorced wife, divorced husband, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father, child, or parent of such individual, or (2) falsely represents to any person that he is an employee or agent of the United States, shall be deemed guilty of a misdemeanor, and, upon conviction thereof, shall be punished by a fine not exceeding $1,000, or by imprisonment not exceeding one year, or both.

LIMITATION ON PAYMENTS TO PUERTO RICO, THE VIRGIN ISLANDS, GUAM, AND AMERICAN SAMOA

SEC. 1108. [42 U.S.C. 1308] (a) The total amount certified by the Secretary of Health and Human Services under titles I, X, XIV, and XVI, and under parts A and E of title IV (exclusive of any amounts on account of services and items to which subsection (b) or, in the case of part A of title IV, section 403(k)[15] applies)—

(1) for payment to Puerto Rico shall not exceed—

(A) $12,500,000 with respect to the fiscal year 1968,

(B) $15,000,000 with respect to the fiscal year 1969,

(C) $18,000,000 with respect to the fiscal year 1970,

(D) $21,000,000 with respect to the fiscal year 1971,

(E) $24,000,000 with respect to each of the fiscal years 1972 through 1978,

(F) $72,000,000 with respect to each of the fiscal years 1979 through 1988, or

(G) $82,000,000 with respect to the fiscal year 1989 and each fiscal year thereafter;

(2) for payment to the Virgin Islands shall not exceed—

(A) $425,000 with respect to the fiscal year 1968,

(B) $500,000 with respect to the fiscal year 1969,

(C) $600,000 with respect to the fiscal year 1970,

(D) $700,000 with respect to the fiscal year 1971,

(E) $800,000 with respect to each of the fiscal years 1972 through 1978,

(F) $2,400,000 with respect to each of the fiscal years 1979 through 1988, or

(G) $2,800,000 with respect to the fiscal year 1989 and each fiscal year thereafter;

(3) for payment to Guam shall not exceed—

(A) $575,000 with respect to the fiscal year 1968,

(B) $690,000 with respect to the fiscal year 1969,

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[15] P.L. 100-485, §202(c)(2), inserted "or, in the case of part A of title IV, section 403(k)". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

(C) $825,000 with respect to the fiscal year 1970,

(D) $960,000 with respect to the fiscal year 1971,

(E) $1,100,000 with respect to each of the fiscal years 1972 through 1978,

(F) $3,300,000 with respect to each of the fiscal years 1979 through 1988, or

(G) $3,800,000 with respect to the fiscal year 1989 and each fiscal year thereafter.

Each jurisdiction specified in this subsection may use in its program under title XX any sums available to it under this subsection which are not needed to carry out the programs specified in this subsection.

(b) The total amount certified by the Secretary under part A of title IV, on account of family planning services[16] with respect to any fiscal year—

(1) for payment to Puerto Rico shall not exceed $2,000,000,

(2) for payment to the Virgin Islands shall not exceed $65,000, and

(3) for payment to Guam shall not exceed $90,000.

(c) The total amount certified by the Secretary under title XIX with respect to a fiscal year for payment to—

(1) Puerto Rico shall not exceed (A) $73,400,000 for fiscal year 1988, (B) $76,200,000 for fiscal year 1989, and (C) $79,000,000 for fiscal year 1990 (and each succeeding fiscal year);

(2) the Virgin Islands shall not exceed (A) $2,430,000 for fiscal year 1988, (B) $2,515,000 for fiscal year 1989, and (C) $2,600,000 for fiscal year 1990 (and each succeeding fiscal year);

(3) Guam shall not exceed (A) $2,320,000 for fiscal year 1988, (B) $2,410,000 for fiscal year 1989, and (C) $2,500,000 for fiscal year 1990 (and each succeeding fiscal year);

(4) the Northern Mariana Islands shall not exceed (A) $636,700 for fiscal year 1988, (B) $693,350 for fiscal year 1989, and (C) $750,000 for fiscal year 1990 (and each succeeding fiscal year); and

(5) American Samoa shall not exceed (A) $1,330,000 for fiscal year 1988, (B) $1,390,000 for fiscal year 1989, and (C) $1,450,000 for fiscal year 1990 (and each succeeding fiscal year).

(d) The total amount certified by the Secretary under parts A and E of title IV with respect to a fiscal year for payment to American Samoa (exclusive of any amounts on account of services and items to which, in the case of part A of such title, section 403(k) applies) shall not exceed $1,000,000.

(e) Notwithstanding the provisions of section 421, and until such time as the Congress may by appropriation or other law otherwise provide, the Secretary shall, in lieu of the initial allotment specified in such sections, allot such smaller amounts to Guam, American Samoa, and the Trust Territory of the Pacific Islands as he may deem appropriate.

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[16] P.L. 100-485, §202(c)(3), struck out "and services provided under section 402(a)(19)". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

AMOUNTS DISREGARDED NOT TO BE TAKEN INTO ACCOUNT IN DETERMINING ELIGIBILITY OF OTHER INDIVIDUALS

SEC. 1109. [42 U.S.C. 1309] Any amount which is disregarded (or set aside for future needs) in determining the eligibility of and amount of the aid or assistance for any individual under a State plan approved under title I, X, XIV, XVI, or XIX, or part A of title IV, shall not be taken into consideration in determining the eligibility of and amount of aid or assistance for any other individual under a State plan approved under any other of such titles.

COOPERATIVE RESEARCH OR DEMONSTRATION PROJECTS[17]

SEC. 1110. [42 U.S.C. 1310] (a)(1) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1957, $5,000,000 and for each fiscal year thereafter such sums as the Congress may determine for (A) making grants to States and public and other organizations and agencies for paying part of the cost of research or demonstration projects such as those relating to the prevention and reduction of dependency, or which will aid in effecting coordination of planning between private and public welfare agencies or which will help improve the administration and effectiveness of programs carried on or assisted under the Social Security Act and programs related thereto, and (B) making contracts or jointly financed cooperative arrangements with States and public and other organizations and agencies for the conduct of research or demonstration projects relating to such matters.

(2) No contract or jointly financed cooperative arrangement shall be entered into, and no grant shall be made, under paragraph (1), until the Secretary obtains the advice and recommendations of specialists who are competent to evaluate the proposed projects as to soundness of their design, the possibilities of securing productive results, the adequacy of resources to conduct the proposed research or demonstrations, and their relationship to other similar research or demonstrations already completed or in process.

(3) Grants and payments under contracts or cooperative arrangements under paragraph (1) may be made either in advance or by way of reimbursement, as may be determined by the Secretary; and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purposes of this subsection.

(b)(1) The Secretary is authorized to waive any of the requirements, conditions, or limitations of title XVI (or to waive them only for specified purposes, or to impose additional requirements, conditions, or limitations) to such extent and for such period as he finds necessary to carry out one or more experimental, pilot, or demonstration projects which, in his judgment, are likely to assist in promoting the objectives or facilitate the administration of such title. Any costs for benefits under or administration of any such project (including planning for the project and the review and evaluation of the project and its results), in excess of those that would have been incurred without regard to the project, shall be met by the Secretary from amounts available to him for this purpose from appropriations made to carry out such title. The costs of any such project which is carried out in coordination with one or more related projects under other titles of this Act shall be allocated among the appropriations available for such projects and any Trust Funds involved, in a manner determined by the Secretary, taking into consideration the programs (or types of benefit) to which the project (or part of a project) is most closely related or which the project (or part of a project) is intended to benefit. If, in order to carry out a project under this subsection, the Secretary requests a State to make supplementary payments (or makes them himself pursuant to an agreement under section 1616), or to provide medical assistance under its plan approved under title XIX, to individuals who are not eligible therefor, or in amounts or under circumstances in which the State does not make such payments or provide such medical assistance, the Secretary shall reimburse such State for the non-Federal share of such payments or assistance from amounts appropriated to carry out title XVI.

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[17] See Vol. II, P.L. 96-265, §505, as amended by P.L. 101-239, §10103(a)(1)-(a)(3) and P.L. 101-508, §5120(f), with respect to authority for demonstration projects and requirements for reports to Congress.

See Vol. II, P.L. 99-190, §126, and P.L. 99-272, §9215, as amended by P.L. 101-239, with respect to the extension of approval of certain Medicare municipal health services demonstration projects.

See Vol. II, P.L. 101-508, §5120, with respect to vocational rehabilitation demonstration projects.

(2) With respect to the participation of recipients of supplemental security income benefits in experimental, pilot, or demonstration projects under this subsection—

(A) the Secretary is not authorized to carry out any project that would result in a substantial reduction in any individual's total income and resources as a result of his or her participation in the project;

(B) the Secretary may not require any individual to participate in a project; and he shall assure (i) that the voluntary participation of individuals in any project is obtained through informed written consent which satisfies the requirements for informed consent established by the Secretary for use in any experimental, pilot, or demonstration project in which human subjects are at risk, and (ii) that any individual's voluntary agreement to participate in any project may be revoked by such individual at any time;

(C) the Secretary shall, to the extent feasible and appropriate, include recipients who are under age 18 as well as adult recipients; and

(D) the Secretary shall include in the projects carried out under this section such experimental, pilot, or demonstration projects as may be necessary to ascertain the feasibility of treating alcoholics and drug addicts to prevent the onset of irreversible medical conditions which may result in permanent disability, including programs in residential care treatment centers.

(3) All reports of the Secretary with respect to projects carried out under this subsection shall be incorporated into the Secretary's annual report to the Congress required by section 704.

PUBLIC ASSISTANCE PAYMENTS TO LEGAL REPRESENTATIVES

SEC. 1111. [42 U.S.C. 1311] For purposes of titles I, X, XIV, and XVI, and part A of title IV, payments on behalf of an individual, made to another person who has been judicially appointed, under the law of the State in which such individual resides, as legal representative of such individual for the purpose of receiving and managing such payments (whether or not he is such individual's legal representative for other purposes), shall be regarded as money payments to such individual.

MEDICAL CARE GUIDES AND REPORTS FOR PUBLIC ASSISTANCE AND MEDICAL ASSISTANCE

SEC. 1112. [42 U.S.C. 1312] In order to assist the States to extend the scope and content, and improve the quality, of medical care and medical services for which payments are made to or on behalf of needy and low-income individuals under this Act and in order to promote better public understanding about medical care and medical assistance for needy and low-income individuals, the Secretary shall develop and revise from time to time guides or recommended standards as to the level, content, and quality of medical care and medical services for the use of the States in evaluating and improving their public assistance medical care programs and their programs of medical assistance; shall secure periodic reports from the States on items included in, and the quantity of, medical care and medical services for which expenditures under such programs are made; and shall from time to time publish data secured from these reports and other information necessary to carry out the purposes of this section.

ASSISTANCE FOR UNITED STATES CITIZENS RETURNED FROM FOREIGN COUNTRIES

SEC. 1113. [42 U.S.C. 1313] (a)(1) The Secretary is authorized to provide temporary assistance to citizens of the United States and to dependents of citizens of the United States, if they (A) are identified by the Department of State as having returned, or been brought, from a foreign country to the United States because of the destitution of the citizen of the United States or the illness of such citizen or any of his dependents or because of war, threat of war, invasion, or similar crisis, and (B) are without available resources.

(2) Except in such cases or classes of cases as are set forth in regulations of the Secretary, provision shall be made for reimbursement to the United States by the recipients of the temporary assistance to cover the cost thereof.

(3) The Secretary may provide assistance under paragraph (1) directly or through utilization of the services and facilities of appropriate public or private agencies and organizations, in accordance with agreements providing for payment, in advance or by way of reimbursement, as may be determined by the Secretary, of the cost thereof. Such cost shall be determined by such statistical, sampling, or other method as may be provided in the agreement.

(b) The Secretary is authorized to develop plans and make arrangements for provision of temporary assistance within the United States to individuals specified in subsection (a)(1). Such plans shall be developed and such arrangements shall be made after consultation with the Secretary of State, the Attorney General, and the Secretary of Defense. To the extent feasible, assistance provided under subsection (a) shall be provided in accordance with the plans developed pursuant to this subsection, as modified from time to time by the Secretary.

(c) For purposes of this section, the term "temporary assistance" means money payments, medical care, temporary billeting, transportation, and other goods and services necessary for the health or welfare of individuals (including guidance, counseling, and other welfare services) furnished to them within the United States upon their arrival in the United States and for such period after their arrival, not exceeding ninety days, as may be provided in regulations of the Secretary; except that assistance under this section may be furnished beyond such ninety-day period in the case of any citizen or dependent upon a finding by the Secretary that the circumstances involved necessitate or justify the furnishing of assistance beyond such period in that particular case.

(d) The total amount of temporary assistance provided under this section shall not exceed $1,000,000 during any fiscal year beginning after September 30, 1991[18].[19]

(e)(1) The Secretary may accept on behalf of the United States gifts, in cash or in kind, for use in carrying out the program established under this section. Gifts in the form of cash shall be credited to the appropriation account from which this program is funded, in addition to amounts otherwise appropriated, and shall remain available until expended.

(2) Gifts accepted under paragraph (1) shall be available for obligation or other use by the United States only to the extent and in the amounts provided in appropriation Acts.[20]

APPOINTMENT OF ADVISORY COUNCIL AND OTHER ADVISORY GROUPS[21]

SEC. 1114. [42 U.S.C. 1314] (a) The Secretary shall, during 1964, appoint an Advisory Council on Public Welfare for the purpose of reviewing the administration of the public assistance and child welfare services programs for which funds are appropriated pursuant to this Act and making recommendations for improvement of such administration, and reviewing the status of and making recommendations with respect to the public assistance programs for which funds are so appropriated, especially in relation to the old-age, survivors, and disability insurance program, with respect to the fiscal capacities of the States and the Federal Government, and with respect to any other matters bearing on the amount and proportion of the Federal and State shares in the public assistance and child welfare services programs.

(b) The Council shall be appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service and shall consist of twelve persons who shall, to the extent possible, be representatives of employers and employees in equal numbers, representatives of State or Federal agencies concerned with the administration or financing of the public assistance and child welfare services programs, representatives of nonprofit private organizations concerned with social welfare programs, other persons with special knowledge, experience, or qualifications with respect to such programs, and members of the public.

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[18] P.L. 101-508, §5056(a)(1), struck out "on or after October 1, 1989" and substituted "after September 30, 1991", effective for fiscal years beginning after September 30, 1989.

[19] P.L. 101-382, §140, amended subsection (d) in its entirety, effective August 20, 1990. [For subsection (d) as it formerly read, see Vol. III, P.L. 101-382.]

[20] P.L. 101-508, §5056(a)(2), added subsection (e), effective for fiscal years beginning after September 30, 1989.

[21] See Vol. II, P.L. 92-463, §§2-15, approved October 6, 1972, with respect to provisions governing the operations of advisory committees.

(c) The Council is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Council such secretarial, clerical, and other assistance and such pertinent data prepared by the Department of Health and Human Services as it may require to carry out such functions.

(d) The Council shall make a report of its findings and recommendations (including recommendations for changes in the provisions of the Social Security Act) to the Secretary, such report to be submitted not later than July 1, 1966, after which date such Council shall cease to exist.

(e) The Secretary shall also from time to time thereafter appoint an Advisory Council on Public Welfare, with the same functions and constituted in the same manner as prescribed for the Advisory Council in the preceding subsections of this section. Each Council so appointed shall report its findings and recommendations, as prescribed in subsection (d), not later than July 1 of the second year after the year in which it is appointed, after which date such Council shall cease to exist.

(f) The Secretary may also appoint, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, such advisory committees as he may deem advisable to advise and consult with him in carrying out any of his functions under this Act. The Secretary shall report to the Congress annually on the number of such committees and on the membership and activities of each such committee.

(g) Members of the Council or of any advisory committee appointed under this section who are not regular full-time employees of the United States shall, while serving on business of the Council or any such committee, be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $75 per day, including travel time; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

(h)(1) Any member of the Council or any advisory committee appointed under this Act, who is not a regular full-time employee of the United States, is hereby exempted, with respect to such appointment, from the operation of sections 203, 205, and 209 of title 18, United States Code, except as otherwise specified in paragraph (2) of this subsection.

(2) The exemption granted by paragraph (1) shall not extend—

(A) to the receipt or payment of salary in connection with the appointee's Government service from any source other than the employer of the appointee at the time of his appointment, or

(B) during the period of such appointment, to the prosecution or participation in the prosecution, by any person so appointed, of any claim against the Government involving any matter with which such person, during such period, is or was directly connected by reason of such appointment.

DEMONSTRATION PROJECTS[22]

SEC. 1115. [42 U.S.C. 1315] (a) In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of title I, X, XIV, XVI, or XIX, or part A or D of title IV, in a State or States—

(1) the Secretary may waive compliance with any of the requirements of section 2, 402, 454, 1002, 1402, 1602, or 1902, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and

(2) costs of such project which would not otherwise be included as expenditures under section 3, 403, 455, 1003, 1403, 1603, or 1903, as the case may be, and which are not included as part of the costs of projects under section 1110, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such title, or for administration of such State plan or plans, as may be appropriate.

In addition, not to exceed $4,000,000 of the aggregate amount appropriated for payments to States under such titles for any fiscal year beginning after June 30, 1967, shall be available, under such terms and conditions as the Secretary may establish, for payments to States to cover so much of the cost of such projects as is not covered by payments under such titles and is not included as part of the cost of projects for purposes of section 1110.[23]

(b)(1) In order to permit the States to achieve more efficient and effective use of funds for public assistance, to reduce dependency, and to improve the living conditions and increase the incomes of individuals who are recipients of public assistance, any State having an approved plan under part A of title IV may, subject to the provisions of this subsection, establish and conduct not more than three demonstration projects. In establishing and conducting any such project the State shall—

(A) provide that not more than one such project be conducted on a statewide basis;

(B) provide that in making arrangements for public service employment—

(i) appropriate standards for the health, safety, and other conditions applicable to the performance of work and training on such project are established and will be maintained,

(ii) such project will not result in the displacement of employed workers,

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[22] See Vol. II, P.L. 99-272, §9220, with respect to the On Lok waiver and §9221 with respect to the "Access: Medicare" demonstration project; and §9523, as amended by P.L. 101-239, §6408(b), with respect to the Texas waiver project.

See Vol. II, P.L. 100-203, §4115, with respect to State demonstration projects.

See Vol. II, P.L. 100-360, §301(g)(1), with respect to any State providing medical assistance to its residents under a waiver granted under this section.

See Vol. II, P.L. 100-485, §§501-502, §505 [as amended by P.L. 101-508, §5063], and §506, with respect to Family Support demonstration projects.

[23] P.L. 100-485, §507, provides that, upon application by the State of Minnesota, the Secretary shall extend until June 30, 1991*, the waiver granted to such State under this subsection to conduct a prepaid medicaid demonstration project.

*P.L. 101-239, §6411(j), struck out "1990" and substituted "1991".

See Vol. II, P.L. 100-485, §507 [as amended by P.L. 101-508, §4733(1)], with respect to the waiver granted to Minnesota.

(iii) each participant in such project shall be compensated for work performed by him at an hourly rate equal to the prevailing hourly wage for similar work in the locality where the participant performs such work (and, for purposes of this clause, benefits payable under the State's plan approved under part A of title IV of the family of which such participant is a member shall be regarded as compensation for work performed by such participant),

(iv) with respect to such project the conditions of work, training, education, and employment are reasonable in the light of such factors as the type of work, geographical region, and proficiency of the participant, and

(v) appropriate workmen's compensation protection is provided to all participants; and

(C) provide that participation in such project by any individual receiving aid to families with dependent children be voluntary.

(2) Any State which establishes and conducts demonstration projects under this subsection may, subject to paragraph (3), with respect to any such project—

(A) waive, subject to paragraph (3), any or all of the requirements of sections 402(a)(1) (relating to statewide operation), 402(a)(3) (relating to administration by a single State agency), 402(a)(8) (relating to disregard of earned income), except that no such waiver of 402(a)(8) shall operate to waive any amount in excess of one-half of the earned income of any individual, and 402(a)(19) (relating to the work incentive program); and

(B) subject to paragraph (4), use to cover the costs of the project such funds as are appropriated for payment to such State with respect to the assistance which is or would, except for participation in a project under this subsection, be payable to individuals participating in such projects under part A of title IV for any fiscal year in which such projects are conducted.

(3)(A) Any State which wishes to establish and conduct demonstration projects under the provisions of this subsection shall submit an application to the Secretary in such form and containing such information as the Secretary may require. Whenever any State submits such an application to the Secretary, it shall at the same time issue public notice of that fact together with a general description of the project with respect to which the application is submitted, and shall invite comment thereon from interested parties and comments thereon may be submitted, within the 30-day period beginning with the date the application is submitted to the Secretary, to the State or the Secretary by such parties. The State shall also make copies of the application available for public inspection. The Secretary shall also immediately publish a summary of the proposed project, make copies of the application available for public inspection, and receive and consider comments submitted with respect to the application. A State shall be authorized to proceed with a project submitted under this subsection—

(i) when such application has been approved by the Secretary (which shall be no earlier than 30 days following the date the application is submitted to him), or

(ii) 60 days after the date on which such application is submitted to the Secretary unless, during such 60 day period, he denies the application.

(B) Notwithstanding the provisions of paragraph (2)(A), the Secretary may review any waiver made by a State under such paragraph. Upon a finding that any such waiver is inconsistent with the purposes of this subsection and the purposes of part A of title IV, the Secretary may disapprove such waiver. The project with respect to which any such disapproved waiver was made shall be terminated by such State not later than the last day of the month following the month in which such waiver was disapproved.

(4) Any amount payable to a State under section 403(a) on behalf of an individual participating in a project under this section shall not be increased by reason of the participation of such individual in any demonstration project conducted under this subsection over the amount which would be payable if such individual were receiving aid to families with dependent children and not participating in such project.

(5) Participation in a project established under this section shall not be considered to constitute employment for purposes of any finding with respect to "unemployment" as that term is used in section 407.

(6) Any demonstration project established and conducted pursuant to the provisions of this subsection shall be conducted for not longer than two years. All demonstration projects established and conducted pursuant to the provisions of this subsection shall be terminated not later than September 30, 1980.

(c) In the case of any experimental, pilot, or demonstration project undertaken under subsection (a) to assist in promoting the objectives of part D of title IV, the project—

(1) must be designed to improve the financial well-being of children or otherwise improve the operation of the child support program;

(2) may not permit modifications in the child support program which would have the effect of disadvantaging children in need of support; and

(3) must not result in increased cost to the Federal Government under the program of aid to families with dependent children.

(d)(1)(A) The Secretary shall enter into agreements with up to 8 States submitting applications under this subsection for the purpose of conducting demonstration projects in such States to test and evaluate the use, with respect to individuals who received aid under part A of title IV in the preceding month (on the basis of the unemployment of the parent who is the principal earner), of a number greater than 100 for the number of hours per month that such individuals may work and still be considered to be unemployed for purposes of section 407. If any State submits an application under this subsection for the purpose of conducting a demonstration project to test and evaluate the total elimination of the 100-hour rule, the Secretary shall approve at least one such application.

(B) If any State with an agreement under this subsection so requests, the demonstration project conducted pursuant to such agreement may test and evaluate the complete elimination of the

100-hour rule and of any other durational standard that might be applied in defining unemployment for purposes of determining eligibility under section 407.

(2) Notwithstanding section 402(a)(1), a demonstration project conducted under this subsection may be conducted in one or more political subdivisions of the State.

(3) An agreement under this subsection shall be entered into between the Secretary and the State agency designated under section 402(a)(3). Such agreement shall provide for the payment of aid under the applicable State plan under part A of title IV as though section 407 had been modified to reflect the definition of unemployment used in the demonstration project but shall also provide that such project shall otherwise be carried out in accordance with all of the requirements and conditions of section 407 (and, except as provided in paragraph (2), any related requirements and conditions under part A of title IV).

(4) A demonstration project under this subsection may be commenced any time after September 30, 1990, and shall be conducted for such period of time as the agreement with the Secretary may provide; except that, in no event may a demonstration project under this section be conducted after September 30, 1995.

(5)(A) Any State with an agreement under this subsection shall evaluate the comparative cost and employment effects of the use of the definition of unemployment in its demonstration project under this section by use of experimental and control groups comprised of a random sample of individuals receiving aid under section 407 and shall furnish the Secretary with such information as the Secretary determines to be necessary to evaluate the results of the project conducted by the State.

(B) The Secretary shall report the results of the demonstration projects conducted under this subsection to the Congress not later than 6 months after all such projects are completed.

ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN ADMINISTRATIVE DETERMINATIONS

SEC. 1116. [42 U.S.C. 1316] (a)(1) Whenever a State plan is submitted to the Secretary by a State for approval under title I, X, XIV, XVI, or XIX, or part A of title IV, he shall, not later than 90 days after the date the plan is submitted to him, make a determination as to whether it conforms to the requirements for approval under such title. The 90-day period provided herein may be extended by written agreement of the Secretary and the affected State.

(2) Any State dissatisfied with a determination of the Secretary under paragraph (1) with respect to any plan may, within 60 days after it has been notified of such determination, file a petition with the Secretary for reconsideration of the issue of whether such plan conforms to the requirements for approval under such title. Within 30 days after receipt of such a petition, the Secretary shall notify the State of the time and place at which a hearing will be held for the purpose of reconsidering such issue. Such hearing shall be held not less than 20 days nor more than 60 days after the date notice of such hearing is furnished to such State, unless the Secretary and such State agree in writing to holding the hearing at another time. The Secretary shall affirm, modify, or reverse his original determination within 60 days of the conclusion of the hearing.

(3) Any State which is dissatisfied with a final determination made by the Secretary on such a reconsideration or a final determination of the Secretary under section 4, 404, 1004, 1404, 1604, or 1904 may, within 60 days after it has been notified of such determination, file with the United States court of appeals for the circuit in which such State is located a petition for review of such determination. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary. The Secretary thereupon shall file in the court the record of the proceedings on which he based his determination as provided in section 2112 of title 28, United States Code.

(4) The findings of fact by the Secretary, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(5) The court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

(b) For the purposes of subsection (a), any amendment of a State plan approved under title I, X, XIV, XVI, or XIX, or part A of title IV, may, at the option of the State, be treated as the submission of a new State plan.

(c) Action pursuant to an initial determination of the Secretary described in subsection (a) shall not be stayed pending reconsideration, but in the event that the Secretary subsequently determines that his initial determination was incorrect he shall certify restitution forthwith in a lump sum of any funds incorrectly withheld or otherwise denied.

(d) Whenever the Secretary determines that any item or class of items on account of which Federal financial participation is claimed under title I, X, XIV, XVI, or XIX, or part A of title IV, shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance.

APPOINTMENT OF THE ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION

SEC. 1117. [42 U.S.C. 1317] The Administrator of the Health Care Financing Administration shall be appointed by the President by and with the advice and consent of the Senate.

ALTERNATIVE FEDERAL PAYMENT WITH RESPECT TO PUBLIC ASSISTANCE EXPENDITURES

SEC. 1118. [42 U.S.C. 1318] In the case of any State which has in effect a plan approved under title XIX for any calendar quarter, the total of the payments to which such State is entitled for such quarter, and for each succeeding quarter in the same fiscal year (which for purposes of this section means the 4 calendar quarters ending with September 30), under paragraphs (1) and (2) of sections

3(a), 403(a), 1003(a), 1403(a), and 1603(a) shall, at the option of the State, be determined by application of the Federal medical assistance percentage (as defined in section 1905), instead of the percentages provided under each such section, to the expenditures under its State plans approved under titles I, X, XIV, and XVI, and part A of title IV, which would be included in determining the amounts of the Federal payments to which such State is entitled under such sections, but without regard to any maximum on the dollar amounts per recipient which may be counted under such sections. For purposes of the preceding sentence, the term "Federal medical assistance percentage" shall, in the case of Puerto Rico, the Virgin Islands, and Guam, mean 75 per centum, and shall, in the case of American Samoa, mean 75 per centum with respect to part A of title IV.

FEDERAL PARTICIPATION IN PAYMENTS FOR REPAIRS TO HOME OWNED BY RECIPIENT OF AID OR ASSISTANCE

Sec. 1119. [42 U.S.C. 1319] In the case of an expenditure for repairing the home owned by an individual who is receiving aid or assistance, other than medical assistance to the aged, under a State plan approved under title I, X, XIV, or XVI, or part A of title IV if—

(1) the State agency or local agency administering the plan approved under such title has made a finding (prior to making such expenditure) that (A) such home is so defective that continued occupancy is unwarranted, (B) unless repairs are made to such home, rental quarters will be necessary for such individual, and (C) the cost of rental quarters to take care of the needs of such individual (including his spouse living with him in such home and any other individual whose needs were taken into account in determining the need of such individual) would exceed (over such time as the Secretary may specify) the cost of repairs needed to make such home habitable together with other costs attributable to continued occupancy of such home, and

(2) no such expenditures were made for repairing such home pursuant to any prior finding under this section,

the amount paid to any such State for any quarter under section 3(a), 403(a), 1003(a), 1403(a), or 1603(a) shall be increased by 50 per centum of such expenditures, except that the excess above $500 expended with respect to any one home shall not be included in determining such expenditures.

APPROVAL OF CERTAIN PROJECTS

Sec. 1120. [42 U.S.C. 1320] No payment shall be made under this Act with respect to any experimental, pilot, demonstration, or other project all or any part of which is wholly financed with Federal funds made available under this Act (without any State, local, or other non-Federal financial participation) unless such project shall have been personally approved by the Secretary or Under Secretary of Health and Human Services.

UNIFORM REPORTING SYSTEMS FOR HEALTH SERVICES FACILITIES AND ORGANIZATIONS

Sec. 1121. [42 U.S.C. 1320a] (a) For the purposes of reporting the cost of services provided by, of planning, and of measuring and comparing the efficiency of and effective use of services in, hospitals, skilled nursing facilities, intermediate care facilities, home health agencies, health maintenance organizations, and other types of health services facilities and organizations to which payment may be made under this Act, the Secretary shall establish by regulation, for each such type of health services facility or organization, a uniform system for the reporting by a facility or organization of that type of the following information:

(1) The aggregate cost of operation and the aggregate volume of services.

(2) The costs and volume of services for various functional accounts and subaccounts.

(3) Rates, by category of patient and class of purchaser.

(4) Capital assets, as defined by the Secretary, including (as appropriate) capital funds, debt service, lease agreements used in lieu of capital funds, and the value of land, facilities, and equipment.

(5) Discharge and bill data.

The uniform reporting system for a type of health services facility or organization shall provide for appropriate variation in the application of the system to different classes of facilities or organizations within that type and shall be established, to the extent practicable, consistent with the cooperative system for producing comparable and uniform health information and statistics described in section 306(e)(1) of the Public Health Service Act[24]. In reporting under such a system, hospitals shall employ such chart of accounts, definitions, principles, and statistics as the Secretary may prescribe in order to reach a uniform reconciliation of financial and statistical data for specified uniform reports to be provided to the Secretary.

(b) The Secretary shall—

(1) monitor the operation of the systems established under subsection (a);

(2) assist with and support demonstrations and evaluations of the effectiveness and cost of the operation of such systems and encourage State adoption of such systems; and

(3) periodically revise such systems to improve their effectiveness and diminish their cost.

(c) The Secretary shall provide information obtained through use of the uniform reporting systems described in subsection (a) in a useful manner and format to appropriate agencies and organizations, including health systems agencies (designated under section 1515 of the Public Health Service Act) and State health planning and development agencies (designated under section 1521 of such Act), as may be necessary to carry out such agencies' and organizations' functions.

LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES[25]

SEC. 1122. [42 U.S.C. 1320a-1] (a) The purpose of this section is to assure that Federal funds appropriated under titles XVIII and XIX are not used to support unnecessary capital expenditures made by or on behalf of health care facilities which are reimbursed under any of such titles and that, to the extent possible, reimbursement under such titles shall support planning activities with respect to health services and facilities in the various States.

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[24] P.L. 78-410.

[25] See Vol. II, Appendix G, the Federal Register of March 31, 1988, with respect to the termination of capital expenditure review agreements under this section.

(b) The Secretary, after consultation with the Governor (or other chief executive officer) and with appropriate local public officials, shall make an agreement with any State which is able and willing to do so under which a designated planning agency (which shall be an agency described in clause (ii) of subsection (d)(1)(B) that has a governing body or advisory board at least half of whose members represent consumer interests) will—

(1) make, and submit to the Secretary together with such supporting materials as he may find necessary, findings and recommendations with respect to capital expenditures proposed by or on behalf of any health care facility in such State within the field of its responsibilities,

(2) receive from other agencies described in clause (ii) of subsection (d)(1)(B), and submit to the Secretary together with such supporting material as he may find necessary, the findings and recommendations of such other agencies with respect to capital expenditures proposed by or on behalf of health care facilities in such State within the fields of their respective responsibilities, and

(3) establish and maintain procedures pursuant to which a person proposing any such capital expenditure may appeal a recommendation by the designated agency and will be granted an opportunity for a fair hearing by such agency or person other than the designated agency as the Governor (or other chief executive officer) may designate to hold such hearings,

whenever and to the extent that the findings of such designated agency or any such other agency indicate that any such expenditure is not consistent with the standards, criteria, or plans developed pursuant to the Public Health Service Act[26] to meet the need for adequate health care facilities in the area covered by the plan or plans so developed.

(c) The Secretary shall pay any such State from the general fund in the Treasury, in advance or by way of reimbursement as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (b).

(d)(1) Except as provided in paragraph (2), if the Secretary determines that—

(A) neither the planning agency designated in the agreement described in subsection (b) nor an agency described in clause (ii) of subparagraph (B) of this paragraph had been given notice of any proposed capital expenditure (in accordance with such procedure or in such detail as may be required by such agency) at least 60 days prior to obligation for such expenditure; or

(B)(i) the planning agency so designated or an agency so described had received such timely notice of the intention to make such capital expenditure and had, within a reasonable period after receiving such notice and prior to obligation for such expenditure, notified the person proposing such expenditure that the expenditure would not be in conformity with the standards, criteria, or plans developed by such agency or any other agency described in clause (ii) for adequate health care facilities in such State or in the area for which such other agency has responsibility, and

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[26] P.L. 78-410.

(ii) the planning agency so designated had, prior to submitting to the Secretary the findings referred to in subsection (b)—

(I) consulted with, and taken into consideration the findings and recommendations of, the State planning agencies established pursuant to sections 314(a) and 604(a) of the Public Health Service Act[27] (to the extent that either such agency is not the agency so designated) as well as the public or nonprofit private agency or organization responsible for the comprehensive regional, metropolitan area, or other local area plan or plans referred to in section 314(b) of the Public Health Service Act and covering the area in which the health care facility proposing such capital expenditure is located (where such agency is not the agency designated in the agreement), or, if there is no such agency, such other public or nonprofit private agency or organization (if any) as performs, as determined in accordance with criteria included in regulations, similar functions, and

(II) granted to the person proposing such capital expenditure an opportunity for a fair hearing with respect to such findings;

then, for such period as he finds necessary in any case to effectuate the purpose of this section, he shall, in determining the Federal payments to be made under titles XVIII and XIX with respect to services furnished in the health care facility for which such capital expenditure is made, not include any amount which is attributable to depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), or other expenses related to such capital expenditure. With respect to any organization which is reimbursed on a per capita or a fixed fee or negotiated rate basis, in determining the Federal payments to be made under titles XVIII and XIX, the Secretary shall exclude an amount which in his judgment is a reasonable equivalent to the amount which would otherwise be excluded under this subsection if payment were to be made on other than a per capita or a fixed fee or negotiated rate basis.

(2) If the Secretary, after submitting the matters involved to the advisory council established or designated under subsection (i), determines that an exclusion of expenses related to any capital expenditure of any health care facility would discourage the operation or expansion of such facility which has demonstrated to his satisfaction proof of capability to provide comprehensive health care services (including institutional services) efficiently, effectively, and economically, or would otherwise be inconsistent with the effective organization and delivery of health services or the effective administration of title XVIII or XIX, he shall not exclude such expenses pursuant to paragraph (1).

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[27] P.L. 78-410.

(e) Where a person obtains under lease or comparable arrangement any facility or part thereof, or equipment for a facility, which would have been subject to an exclusion under subsection (d) if the person had acquired it by purchase, the Secretary shall (1) in computing such person's rental expense in determining the Federal payments to be made under titles XVIII and XIX with respect to services furnished in such facility, deduct the amount which in his judgment is a reasonable equivalent of the amount that would have been excluded if the person had acquired such facility or such equipment by purchase, and (2) in computing such person's return on equity capital deduct any amount deposited under the terms of the lease or comparable arrangement.

(f) Any person dissatisfied with a determination by the Secretary under this section may within six months following notification of such determination request the Secretary to reconsider such determination. A determination by the Secretary under this section shall not be subject to administrative or judicial review.

(g) For the purposes of this section, a "capital expenditure" is an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (1) exceeds $600,000 (or such lesser amount as the State may establish), (2) changes the bed capacity of the facility with respect to which such expenditure is made, or (3) substantially changes the services of the facility with respect to which such expenditure is made. For purposes of clause (1) of the preceding sentence, the cost of the studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is made shall be included in determining whether such expenditure exceeds the dollar amount specified in clause (1).

(h) The provisions of this section shall not apply to Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

(i)(1) The Secretary shall establish a national advisory council, or designate an appropriate existing national advisory council, to advise and assist him in the preparation of general regulations to carry out the purposes of this section and on policy matters arising in the administration of this section, including the coordination of activities under this section with those under other parts of this Act or under other Federal or federally assisted health programs.

(2) The Secretary shall make appropriate provision for consultation between and coordination of the work of the advisory council established or designated under paragraph (1) and the Federal Hospital Council, the National Advisory Health Council, the Health Insurance Benefits Advisory Council, and other appropriate national advisory councils with respect to matters bearing on the purposes and administration of this section and the coordination of activities under this section with related Federal health programs.

(3) If an advisory council is established by the Secretary under paragraph (1), it shall be composed of members who are not otherwise in the regular full-time employ of the United States, and who shall be appointed by the Secretary without regard to the civil service laws from among leaders in the fields of the fundamental

sciences, the medical sciences, and the organization, delivery, and financing of health care, and persons who are State or local officials or are active in community affairs or public or civic affairs or who are representative of minority groups. Members of such advisory council, while attending meetings of the council or otherwise serving on business of the council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the maximum rate specified at the time of such service for grade GS-18 in section 5332 of title 5, United States Code, including traveltime, and while away from their homes or regular places of business they may also be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of such title 5 for persons in the Government service employed intermittently.

(j) A capital expenditure made by or on behalf of a health care facility shall not be subject to review pursuant to this section if 75 percent of the patients who can reasonably be expected to use the service with respect to which the capital expenditure is made will be individuals enrolled in an eligible organization as defined in section 1876(b), and if the Secretary determines that such capital expenditure is for services and facilities which are needed by such organization in order to operate efficiently and economically and which are not otherwise readily accessible to such organization because—

(1) the facilities do not provide common services at the same site (as usually provided by the organization),

(2) the facilities are not available under a contract of reasonable duration,

(3) full and equal medical staff privileges in the facilities are not available,

(4) arrangements with such facilities are not administratively feasible, or

(5) the purchase of such services is more costly than if the organization provided the services directly.

[SEC. 1123. Repealed.[28]]

DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION[29]

SEC. 1124. [42 U.S.C. 1320a-3] (a)(1) The Secretary shall by regulation or by contract provision provide that each disclosing entity (as defined in paragraph (2)) shall—

(A) as a condition of the disclosing entity's participation in, or certification or recertification under, any of the programs established by titles V, XVIII, and XIX, or

(B) as a condition for the approval or renewal of a contract or agreement between the disclosing entity and the Secretary or the appropriate State agency under any of the programs established under titles V, XVIII, and XIX,

supply the Secretary or the appropriate State agency with full and complete information as to the identity of each person with an ownership or control interest (as defined in paragraph (3)) in the entity or in any subcontractor (as defined by the Secretary in regulations) in which the entity directly or indirectly has a 5 per centum or more ownership interest.

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[28] P.L. 100-360, §430(a) [as added by P.L. 100-485, §608(b)]; 102 Stat. 2412.

[29] See Vol. II, P.L. 78-410, §1318, with respect to financial disclosure.

(2) As used in this section, the term "disclosing entity" means an entity which is—

(A) a provider of services (as defined in section 1861(u), other than a fund), an independent clinical laboratory, a renal disease facility, or a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act[30]);

(B) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, items or services with respect to which payment may be claimed by the entity under any plan or program established pursuant to title V or under a State plan approved under title XIX; or

(C) a carrier or other agency or organization that is acting as a fiscal intermediary or agent with respect to one or more providers of services (for purposes of part A or part B of title XVIII, or both, or for purposes of a State plan approved under title XIX) pursuant to (i) an agreement under section 1816, (ii) a contract under section 1842, or (iii) an agreement with a single State agency administering or supervising the administration of a State plan approved under title XIX.

(3) As used in this section, the term "person with an ownership or control interest" means, with respect to an entity, a person who—

(A)(i) has directly or indirectly (as determined by the Secretary in regulations) an ownership interest of 5 per centum or more in the entity; or

(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 per centum of the total property and assets of the entity; or

(B) is an officer or director of the entity, if the entity is organized as a corporation; or

(C) is a partner in the entity, if the entity is organized as a partnership.

(b) To the extent determined to be feasible under regulations of the Secretary, a disclosing entity shall also include in the information supplied under subsection (a)(1), with respect to each person with an ownership or control interest in the entity, the name of any other disclosing entity with respect to which the person is a person with an ownership or control interest.

DISCLOSURE REQUIREMENTS FOR OTHER PROVIDERS UNDER PART B OF MEDICARE[31]

SEC. 1124A. [42 U.S.C. 1320a-3a] (a) DISCLOSURE REQUIRED TO RECEIVE PAYMENT.—No payment may be made under part B of title XVIII for items or services furnished by any disclosing part B provider unless such provider has provided the Secretary with full and complete information—

(1) on the identity of each person with an ownership or control interest in the provider or in any subcontractor (as defined by the Secretary in regulations) in which the provider directly or indirectly has a 5 percent or more ownership interest; and

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[30] P.L. 78-410.

[31] P.L. 101-508, §4164(b)(1), added §1124A. For the effective date, see Vol. II, P.L. 101-508, §4164(b)(4).

(2) with respect to any person identified under paragraph (1) or any managing employee of the provider—

(A) on the identity of any other entities providing items or services for which payment may be made under title XVIII of the Social Security Act with respect to which such person or managing employee is a person with an ownership or control interest at the time such information is supplied or at any time during the 3-year period ending on the date such information is supplied, and

(B) as to whether any penalties, assessments, or exclusions have been assessed against such person or managing employee under section 1128, 1128A, or 1128B.

(b) UPDATES TO INFORMATION SUPPLIED.—A disclosing part B provider shall notify the Secretary of any changes or updates to the information supplied under subsection (a) not later than 180 days after such changes or updates take effect.

(c) DEFINITIONS.—For purposes of this section—

(1) the term "disclosing part B provider" means any entity receiving payment on an assignment-related basis for furnishing items or services for which payment may be made under part B of title XVIII, except that such term does not include an entity described in section 1124(a)(2);

(2) the term "managing employee" means, with respect to a provider, a person described in section 1126(b); and

(3) the term "person with an ownership or control interest" means, with respect to a provider—

(A) a person described in section 1124(a)(3), or

(B) a person who has one of the 5 largest direct or indirect ownership or control interests in the provider.

ISSUANCE OF SUBPENAS BY COMPTROLLER GENERAL

SEC. 1125. [42 U.S.C. 1320a-4] (a) For the purpose of any audit, investigation, examination, analysis, review, evaluation, or other function authorized by law with respect to any program authorized under this Act, the Comptroller General of the United States shall have power to sign and issue subpenas to any person requiring the production of any pertinent books, records, documents, or other information. Subpenas so issued by the Comptroller General shall be served by anyone authorized by him (1) by delivering a copy thereof to the person named therein, or (2) by registered mail or by certified mail addressed to such person at his last dwelling place or principal place of business. A verified return by the person so serving the subpena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post office receipt therefor signed by the person so served, shall be proof of service.

(b) In case of contumacy by, or refusal to obey a subpena issued pursuant to subsection (a) of this section and duly served upon, any person, any district court of the United States for the judicial district in which such person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Comptroller General, shall have jurisdiction to issue an order requiring such person to produce the books, records, documents, or other information sought by the subpena; and any failure to obey such order of the court may be punished by the court as a contempt thereof. In proceedings brought under this subsection, the Comptroller General shall be represented by attorneys employed in the General Accounting Office or by counsel whom he may employ without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and the provisions of chapter 51 and subchapters III and VI of chapter 53 of such title, relating to classification and General Schedule pay rates.

(c) No personal medical record in the possession of the General Accounting Office shall be subject to subpena or discovery proceedings in a civil action.

DISCLOSURE BY INSTITUTIONS, ORGANIZATIONS, AND AGENCIES OF OWNERS AND CERTAIN OTHER INDIVIDUALS WHO HAVE BEEN CONVICTED OF CERTAIN OFFENSES

SEC. 1126. [42 U.S.C. 1320a-5] (a) As a condition of participation in or certification or recertification under the programs established by titles XVIII, and XIX, any hospital, nursing facility, or other entity (other than an individual practitioner or group of practitioners) shall be required to disclose to the Secretary or to the appropriate State agency the name of any person that is a person described in subparagraphs (A) and (B) of section 1128(b)(8). The Secretary or the appropriate State agency shall promptly notify the Inspector General in the Department of Health and Human Services of the receipt from any entity of any application or request for such participation, certification, or recertification which discloses the name of any such person, and shall notify the Inspector General of the action taken with respect to such application or request.

(b) For the purposes of this section, the term "managing employee" means, with respect to an entity, an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity.

ADJUSTMENTS IN SSI BENEFITS ON ACCOUNT OF RETROACTIVE BENEFITS UNDER TITLE II

SEC. 1127. [42 U.S.C. 1320a-6] (a) Notwithstanding any other provision of this Act, in any case where an individual—

(1) is entitled to benefits under title II that were not paid in the months in which they were regularly due; and

(2) is an individual or eligible spouse eligible for supplemental security income benefits for one or more months in which the benefits referred to in clause (1) were regularly due,

then any benefits under title II that were regularly due in such month or months, or supplemental security income benefits for such month or months, which are due but have not been paid to such individual or eligible spouse shall be reduced by an amount equal to so much of the supplemental security income benefits, whether or not paid retroactively, as would not have been paid or would not be paid with respect to such individual or spouse if he had received such benefits under title II in the month or months in which they were regularly due. A benefit under title II shall not be reduced pursuant to the preceding sentence to the extent that any amount of such benefit would not otherwise be available for payment in full of the maximum fee which may be recovered from such benefit by an attorney pursuant to section 206(a)(4).[32]

(b) For purposes of this section, the term "supplemental security income benefits" means benefits paid or payable by the Secretary under title XVI, including State supplementary payments under an agreement pursuant to section 1616(a) or an administration agreement under section 212(b) of Public Law 93-66.

(c) From the amount of the reduction made under subsection (a), the Secretary shall reimburse the State on behalf of which supplementary payments were made for the amount (if any) by which such State's expenditures on account of such supplementary payments for the month or months involved exceeded the expenditures which the State would have made (for such month or months) if the individual had received the benefits under title II at the times they were regularly due. An amount equal to the portion of such reduction remaining after reimbursement of the State under the preceding sentence shall be covered into the general fund of the Treasury.

EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

SEC. 1128. [42 U.S.C. 1320a-7] (a) MANDATORY EXCLUSION.—The Secretary shall exclude the following individuals and entities from participation in any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program (as defined in subsection (h)):

(1) CONVICTION OF PROGRAM-RELATED CRIMES.—Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under title XVIII or under any State health care program.

(2) CONVICTION RELATING TO PATIENT ABUSE.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.

(b) PERMISSIVE EXCLUSION.—The Secretary may exclude the following individuals and entities from participation in any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program:

(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

(2) CONVICTION RELATING TO OBSTRUCTION OF AN INVESTIGATION.—Any individual or entity that has been convicted, under Federal or State law, in connection with the interference with or obstruction of any investigation into any criminal offense described in paragraph (1) or in subsection (a).

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[32] P.L. 101-508, §5106(b), added this sentence, applicable to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after April 1, 1991.

(3) CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(4) LICENSE REVOCATION OR SUSPENSION.—Any individual or entity—

(A) whose license to provide health care has been revoked or suspended by any State licensing authority, or who otherwise lost such a license or the right to apply for or renew such a license[33], for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity, or

(B) who surrendered such a license while a formal disciplinary proceeding was pending before such an authority and the proceeding concerned the individual's or entity's professional competence, professional performance, or financial integrity.

(5) EXCLUSION OR SUSPENSION UNDER FEDERAL OR STATE HEALTH CARE PROGRAM.—Any individual or entity which has been suspended or excluded from participation, or otherwise sanctioned, under—

(A) any Federal program, including programs of the Department of Defense or the Veterans' Administration, involving the provision of health care, or

(B) a State health care program,

for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.

(6) CLAIMS FOR EXCESSIVE CHARGES OR UNNECESSARY SERVICES AND FAILURE OF CERTAIN ORGANIZATIONS TO FURNISH MEDICALLY NECESSARY SERVICES.—Any individual or entity that the Secretary determines—

(A) has submitted or caused to be submitted bills or requests for payment (where such bills or requests are based on charges or cost) under title XVIII or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished substantially in excess of such individual's or entity's usual charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs;

(B) has furnished or caused to be furnished items or services to patients (whether or not eligible for benefits under title XVIII or under a State health care program) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care;

(C) is—

(i) a health maintenance organization (as defined in section 1903(m)) providing items and services under a State plan approved under title XIX, or

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[33] P.L. 101-239, §6411(d)(1), inserted "or the right to apply for or renew such a license", effective December 19, 1989.

(ii) an entity furnishing services under a waiver approved under section 1915(b)(1),

and has failed substantially to provide medically necessary items and services that are required (under law or the contract with the State under title XIX) to be provided to individuals covered under that plan or waiver, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals; or

(D) is an entity providing items and services as an eligible organization under a risk-sharing contract under section 1876 and has failed substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under the risk-sharing contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals.

(7) FRAUD, KICKBACKS, AND OTHER PROHIBITED ACTIVITIES.—Any individual or entity that the Secretary determines has committed an act which is described in section 1128A or section 1128B.

(8) ENTITIES CONTROLLED BY A SANCTIONED INDIVIDUAL.—Any entity with respect to which the Secretary determines that a person—

(A)(i) who has a direct or indirect ownership or control interest of 5 percent or more in the entity or with an ownership or control interest (as defined in section 1124(a)(3)) in that entity, or

(ii) who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of that entity—

is a person—

(B)(i) who has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection;

(ii) against whom a civil monetary penalty has been assessed under section 1128A; or

(iii) who has been excluded from participation under a program under title XVIII or under a State health care program.[34]

(9) FAILURE TO DISCLOSE REQUIRED INFORMATION.—Any entity that did not fully and accurately make any disclosure required by section 1124, section 1124A,[35] or section 1126.

(10) FAILURE TO SUPPLY REQUESTED INFORMATION ON SUBCONTRACTORS AND SUPPLIERS.—Any disclosing entity (as defined in section 1124(a)(2)) that fails to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to the entity by the Secretary or by the State agency administering or supervising the administration of a State health care program—

(A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom the entity has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000, or

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[34] For purposes of §1128(b)(8)(B)(iii), a person shall be considered to have been excluded from participation under a program under title XVIII if payment to the person has been denied under section 1862(d) as in effect before September 1, 1987.

[35] P.L. 101-508, §4164(b)(3), inserted ", section 1124A,". For the effective date, see Vol. II, P.L. 101-508, §4164(b)(4).

(B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between the entity and any wholly owned supplier or between the entity and any subcontractor.

(11) FAILURE TO SUPPLY PAYMENT INFORMATION.—Any individual or entity furnishing items or services for which payment may be made under title XVIII or a State health care program that fails to provide such information as the Secretary or the appropriate State agency finds necessary to determine whether such payments are or were due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary or that agency as may be necessary to verify such information.

(12) FAILURE TO GRANT IMMEDIATE ACCESS.—Any individual or entity that fails to grant immediate access, upon reasonable request (as defined by the Secretary in regulations) to any of the following:

(A) To the Secretary, or to the agency used by the Secretary, for the purpose specified in the first sentence of section 1864(a) (relating to compliance with conditions of participation or payment).

(B) To the Secretary or the State agency, to perform the reviews and surveys required under State plans under paragraphs (26), (31), and (33) of section 1902(a) and under section 1903(g).

(C) To the Inspector General of the Department of Health and Human Services, for the purpose of reviewing records, documents, and other data necessary to the performance of the statutory functions of the Inspector General.

(D) To a State medicaid fraud control unit (as defined in section 1903(q)), for the purpose of conducting activities described in that section.

(13) FAILURE TO TAKE CORRECTIVE ACTION.—Any hospital that fails to comply substantially with a corrective action required under section 1886(f)(2)(B).

(14) DEFAULT ON HEALTH EDUCATION LOAN OR SCHOLARSHIP OBLIGATIONS.—Any individual who the Secretary determines is in default on repayments of scholarship obligations or loans in connection with health professions education made or secured, in whole or in part, by the Secretary and with respect to whom the Secretary has taken all reasonable steps available to the Secretary to secure repayment of such obligations or loans, except that (A) the Secretary shall not exclude pursuant to this paragraph a physician who is the sole community physician or sole source of essential specialized services in a community if a State requests that the physician not be excluded, and (B) the Secretary shall take into account, in determining whether to exclude any other physician pursuant to this paragraph, access of beneficiaries to physician services for which payment may be made under title XVIII or XIX.

(c) NOTICE, EFFECTIVE DATE, AND PERIOD OF EXCLUSION.—(1) An exclusion under this section or under section 1128A shall be effective at such time and upon such reasonable notice to the public and to the individual or entity excluded as may be specified in regulations consistent with paragraph (2).

(2)(A) Except as provided in subparagraph (B), such an exclusion shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion.

(B) Unless the Secretary determines that the health and safety of individuals receiving services warrants the exclusion taking effect earlier, an exclusion shall not apply to payments made under title XVIII or under a State health care program for—

(i) inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion, or

(ii) home health services and hospice care furnished to an individual under a plan of care established before the date of the exclusion,

until the passage of 30 days after the effective date of the exclusion.

(3)(A) The Secretary shall specify, in the notice of exclusion under paragraph (1) and the written notice under section 1128A, the minimum period (or, in the case of an exclusion of an individual under subsection (b)(12), the period) of the exclusion.

(B) In the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of a State, the Secretary may waive the exclusion under subsection (a)(1) in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community. The Secretary's decision whether to waive the exclusion shall not be reviewable.

(C) In the case of an exclusion of an individual under subsection (b)(12), the period of the exclusion shall be equal to the sum of—

(i) the length of the period in which the individual failed to grant the immediate access described in that subsection, and

(ii) an additional period, not to exceed 90 days, set by the Secretary.

(d) NOTICE TO STATE AGENCIES AND EXCLUSION UNDER STATE HEALTH CARE PROGRAMS.—(1) Subject to paragraph (3), the Secretary shall exercise the authority under this section and section 1128A in a manner that results in an individual's or entity's exclusion from all the programs under title XVIII and all the State health care programs in which the individual or entity may otherwise participate.

(2) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 304(a)(5) of the Controlled Substances Act[36] may apply, the Attorney General)—

(A) of the fact and circumstances of each exclusion effected against an individual or entity under this section or section 1128A, and

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[36] P.L. 91-513; Title II.

(B) of the period (described in paragraph (3)) for which the State agency is directed to exclude the individual or entity from participation in the State health care program.

(3)(A) Except as provided in subparagraph (B), the period of the exclusion under a State health care program under paragraph (2) shall be the same as any period of exclusion under title XVIII.

(B)(i) The Secretary may waive an individual's or entity's exclusion under a State health care program under paragraph (2) if the Secretary receives and approves a request for the waiver with respect to the individual or entity from the State agency administering or supervising the administration of the program.

(ii) A State health care program may provide for a period of exclusion which is longer than the period of exclusion under title XVIII.

(e) NOTICE TO STATE LICENSING AGENCIES.—The Secretary shall—

(1) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of an individual or entity excluded (or directed to be excluded) from participation under this section or section 1128A, of the fact and circumstances of the exclusion,

(2) request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and

(3) request that the State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to the request.

(f) NOTICE, HEARING, AND JUDICIAL REVIEW.—(1) Subject to paragraph (2), any individual or entity that is excluded (or directed to be excluded) from participation under this section is entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(2) Unless the Secretary determines that the health or safety of individuals receiving services warrants the exclusion taking effect earlier, any individual or entity that is the subject of an adverse determination under subsection (b)(7) shall be entitled to a hearing by an administrative law judge (as provided under section 205(b)) on the determination under subsection (b)(7) before any exclusion based upon the determination takes effect.

(3) The provisions of section 205(h) shall apply with respect to this section and sections 1128A and 1156 to the same extent as it is applicable with respect to title II.

(g) APPLICATION FOR TERMINATION OF EXCLUSION.—(1) An individual or entity excluded (or directed to be excluded) from participation under this section or section 1128A may apply to the Secretary, in the manner specified by the Secretary in regulations and at the end of the minimum period of exclusion provided under subsection (c)(3) and at such other times as the Secretary may provide, for termination of the exclusion effected under this section or section 1128A.

(2) The Secretary may terminate the exclusion if the Secretary determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion, that—

(A) there is no basis under subsection (a) or (b) or section 1128A(a) for a continuation of the exclusion, and

(B) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.

(3) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 304(a)(5) of the Controlled Substances Act[37] may apply, the Attorney General) of the fact and circumstances of each termination of exclusion made under this subsection.

(h) Definition of State Health Care Program.—For purposes of this section and sections 1128A and 1128B, the term "State health care program" means—

(1) a State plan approved under title XIX,

(2) any program receiving funds under title V or from an allotment to a State under such title, or

(3) any program receiving funds under title XX or from an allotment to a State under such title.

(i) Convicted Defined.—For purposes of subsections (a) and (b), an individual or entity is considered to have been "convicted" of a criminal offense—

(1) when a judgment of conviction has been entered against the individual or entity by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;

(2) when there has been a finding of guilt against the individual or entity by a Federal, State, or local court;

(3) when a plea of guilty or nolo contendere by the individual or entity has been accepted by a Federal, State, or local court; or

(4) when the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld.

CIVIL MONETARY PENALTIES

Sec. 1128A. [42 U.S.C. 1320a-7a] (a) Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5)) that—

(1) presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)[38](1)), a claim (as defined in subsection (i)[39](2)) that the Secretary determines—

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[37] P.L. 91-513; Title II.

[38] P.L. 99-509, §9313(c)(1)(B), struck out "(h)" and substituted "(i)", applicable to payments by hospitals occurring more than 6 months after October 21, 1986, and payments by eligible organizations or entities occurring on or after April 1, 1991[*].

[*] P.L. 100-203, §4016, changed "1989" to "1990", effective December 22, 1987.

P.L. 101-239, §6207(a), struck out "1990" and substituted "1991", effective December 19, 1989.

[39] P.L. 99-509, §9313(c)(1)(B), struck out "(h)" and substituted "(i)", applicable to payments by hospitals occurring more than 6 months after October 21, 1986, and payments by eligible organizations or entities occurring on or after April 1, 1991[*].

[*] P.L. 100-203, §4016, changed "1989" to "1990", effective December 22, 1987.

P.L. 101-239, §6207(a), struck out "1990" and substituted "1991", effective December 19, 1989.

(A) is for a medical or other item or service that the person knows or should know was not provided as claimed,

(B) is for a medical or other item or service and the person knows or should know the claim is false or fraudulent,

(C) is presented for a physician's service (or an item or service incident to a physician's service) by a person who knows or should know that the individual who furnished (or supervised the furnishing of) the service—

(i) was not licensed as a physician,

(ii) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing), or

(iii) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified, or

(D) is for a medical or other item or service furnished during a period in which the person was excluded from the program under which the claim was made pursuant to a determination by the Secretary under this section or under section 1128, 1156, 1160(b) (as in effect on September 2, 1982), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987[40]), or 1866(b) or as a result of the application of the provisions of section 1842(j)(2); or[41]

(2) presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1842(b)(3)(B)(ii), or (B) an agreement with a State agency (or other requirement of a State plan under title XIX) not to charge a person for an item or service in excess of the amount permitted to be charged, or (C) an agreement to be a participating physician or supplier under section 1842(h)(1)[42], or (D) an agreement pursuant to section 1866(a)(1)(G), or[43]

(3) gives to any person, with respect to coverage under title XVIII of inpatient hospital services subject to the provisions of section 1886, information that he knows or should know is false or misleading, and that could reasonably be expected to influence the decision when to discharge such person or another individual from the hospital;[44]

⟦(4) Repealed.[45]⟧

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each item or service (or, in cases under paragraph (3), $15,000 for each individual with respect to whom false or misleading information was given). In addition, such a person shall be subject to an assessment of not more than twice the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim. In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the programs under title XVIII and to direct the appropriate State agency to exclude the person from participation in any State health care program.

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[40] August 18, 1987 [P.L. 100-93].

[41] P.L. 101-234, §201(a)(1), inserted "or".

[42] P.L. 100-360, §202(c)(2)(B), inserted "or to be a participating pharmacy under section 1842(o)", applicable to items dispensed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed P.L. 100-360, §202, effective January 1, 1990.

[43] P.L. 101-234, §201(a)(1), struck out the semicolon and substituted ", or".

[44] P.L. 101-234, §201(a)(1), struck out "or".

[45] P.L. 100-360, §202(c)(2)(E), added paragraph (4), applicable to items dispensed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed P.L. 100-360, §202, effective January 1, 1990. ⟦For paragraph (4) as it formerly read, see Vol. III, P.L. 101-234.⟧

(b)(1) If a hospital or a rural primary care hospital[46] knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals who—

(A) are entitled to benefits under part A or part B of title XVIII or to medical assistance under a State plan approved under title XIX, and[47]

(B)[48] are under the direct care of the physician,

the hospital or a rural primary care hospital[49] shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each such individual with respect to whom the payment is made.

(2) Any physician who knowingly accepts receipt of a payment described in paragraph (1) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each individual described in such paragraph with respect to whom the payment is made.[50]

(c)[51](1) The Secretary may initiate a proceeding to determine whether to impose a civil money penalty, assessment, or exclusion under subsection (a) or (b)[52] only as authorized by the Attorney General pursuant to procedures agreed upon by them. The Secretary may not initiate an action under this section with respect to any claim, request for payment, or other occurrence described in this section later than six years after the date the claim was presented, the request for payment was made, or the occurrence took place. The Secretary may initiate an action under this section by serving notice of the action in any manner authorized by Rule 4 of the Federal Rules of Civil Procedure.

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[46] P.L. 101-239, §6003(g)(3)(D)(i), inserted "or a rural primary care hospital", effective December 19, 1989.

P.L. 101-508, §4204(a)(3)(A), struck out ", an eligible organization with a risk-sharing contract under section 1876,", effective November 5, 1990.

P.L. 101-508, §4731(b)(1), struck out "or an entity with a contract under section 1903(m)", effective November 5, 1990.

[47] P.L. 101-508, §4204(a)(3)(B), added "and".

[48] P.L. 101-508, §4204(a)(3)(C), struck out subparagraph (B), effective November 5, 1990. [For subparagraph (B) as it reads until then, see Vol. III, P.L. 101-508.]

P.L. 101-508, §4204(a)(3)(D), redesignated subparagraph (C) as subparagraph (B).

[49] P.L. 101-239, §6003(g)(3)(D)(i), inserted "or a rural primary care hospital", effective December 19, 1989.

P.L. 101-508, §4204(a)(3)(E), struck out "or organization", effective November 5, 1990.

[50] P.L. 99-509, §9313(c)(1)(E), added this subsection (b), applicable to payments by hospitals occurring more than 6 months after October 21, 1986, and payments by eligible organizations or entities occurring on or after April 1, 1991*.

*P.L. 100-203, §4016, changed "1989" to "1990", effective December 22, 1987.

P.L. 101-239, §6207(a), struck out "1990" and substituted "1991", effective December 19, 1989.

[51] P.L. 99-509, §9313(c)(1)(D), redesignated the former subsection (b) as subsection (c), applicable to payments by hospitals occurring more than 6 months after October 21, 1986, and payments by eligible organizations or entities occurring on or after April 1, 1991*.

*P.L. 100-203, §4016, changed "1989" to "1990", effective December 22, 1987.

P.L. 101-239, §6207(a), struck out "1990" and substituted "1991", effective December 19, 1989.

[52] P.L. 99-509, §9313(c)(1)(A), inserted "or (b)", applicable to payments by hospitals occurring more than 6 months after October 21, 1986, and payments by eligible organizations or entities occurring on or after April 1, 1991*.

*P.L. 100-203, §4016, changed "1989" to "1990", effective December 22, 1987.

P.L. 101-239, §6207(a), struck out "1990" and substituted "1991", effective December 19, 1989.

(2) The Secretary shall not make a determination adverse to any person under subsection (a) or (b)[53] until the person has been given written notice and an opportunity for the determination to be made on the record after a hearing at which the person is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the person.

(3) In a proceeding under subsection (a) or (b) which—

(A) is against a person who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal crime charging fraud or false statements, and

(B) involves the same transaction as in the criminal action,

the person is estopped from denying the essential elements of the criminal offense.

(4) The official conducting a hearing under this section may sanction a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an action, or other misconduct as would interfere with the speedy, orderly, or fair conduct of the hearing. Such sanction shall reasonably relate to the severity and nature of the failure or misconduct. Such sanction may include—

(A) in the case of refusal to provide or permit discovery, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established,

(B) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense,

(C) striking pleadings, in whole or in part,

(D) staying the proceedings,

(E) dismissal of the action,

(F) entering a default judgment,

(G) ordering the party or attorney to pay attorneys' fees and other costs caused by the failure or misconduct, and

(H) refusing to consider any motion or other action which is not filed in a timely manner.

(d)[54] In determining the amount or scope of any penalty, assessment, or exclusion imposed pursuant to subsection (a) or (b)[55], the Secretary shall take into account—

(1) the nature of claims and the circumstances under which they were presented,

(2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims, and

(3) such other matters as justice may require.

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[53] P.L. 99-509, §9313(c)(1)(A), inserted "or (b)", applicable to payments by hospitals occurring more than 6 months after October 21, 1986, and payments by eligible organizations or entities occurring on or after April 1, 1991*.

*P.L. 100-203, §4016, changed "1989" to "1990", effective December 22, 1987.

P.L. 101-239, §6207(a), struck out "1990" and substituted "1991", effective December 19, 1989.

[54] P.L. 99-509, §9313(c)(1)(D), redesignated the former subsection (c) as subsection (d), applicable to payments by hospitals occurring more than 6 months after October 21, 1986, and payments by eligible organizations or entities occurring on or after April 1, 1991*.

*P.L. 100-203, §4016, changed "1989" to "1990", effective December 22, 1987.

P.L. 101-239, §6207(a), struck out "1990" and substituted "1991", effective December 19, 1989.

[55] P.L. 99-509, §9313(c)(1)(A), inserted "or (b)", applicable to payments by hospitals occurring more than 6 months after October 21, 1986, and payments by eligible organizations or entities occurring on or after April 1, 1991*.

*P.L. 100-203, §4016, changed "1989" to "1990", effective December 22, 1987.

P.L. 101-239, §6207(a), struck out "1990" and substituted "1991", effective December 19, 1989.

(e)[56] Any person adversely affected by a determination of the Secretary under this section may obtain a review of such determination in the United States Court of Appeals for the circuit in which the person resides, or in which the claim was presented, by filing in such court (within sixty days following the date the person is notified of the Secretary's determination) a written petition requesting that the determination be modified or set aside. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, and thereupon the Secretary shall file in the Court the record in the proceeding as provided in section 2112 of title 28, United States Code. Upon such filing, the court shall have jurisdiction of the proceeding and of the question determined therein, and shall have the power to make and enter upon the pleadings, testimony, and proceedings set forth in such record a decree affirming, modifying, remanding for further consideration, or setting aside, in whole or in part, the determination of the Secretary and enforcing the same to the extent that such order is affirmed or modified. No objection that has not been urged before the Secretary shall be considered by the court, unless the failure or neglect to urge such objection shall be excused because of extraordinary circumstances. The findings of the Secretary with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive. If any party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the hearing before the Secretary, the court may order such additional evidence to be taken before the Secretary and to be made a part of the record. The Secretary may modify his findings as to the facts, or make new findings, by reason of additional evidence so taken and filed, and he shall file with the court such modified or new findings, which findings with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive, and his recommendations, if any, for the modification or setting aside of his original order. Upon the filing of the record with it, the jurisdiction of the court shall be exclusive and its judgment and decree shall be final, except that the same shall be subject to review by the Supreme Court of the United States, as provided in section 1254 of title 28, United States Code.

(f)[57] Civil money penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in United States district court for the district where the claim was presented, or where the claimant resides, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

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[56] P.L. 99-509, §9313(c)(1)(D), redesignated the former subsection (d) as subsection (e), applicable to payments by hospitals occurring more than 6 months after October 21, 1986, and payments by eligible organizations or entities occurring on or after April 1, 1991*.

*P.L. 100-203, §4016, changed "1989" to "1990", effective December 22, 1987.

P.L. 101-239, §6207(a), struck out "1990" and substituted "1991", effective December 19, 1989.

[57] P.L. 99-509, §9313(c)(1)(D), redesignated the former subsection (e) as subsection (f), applicable to payments by hospitals occurring more than 6 months after October 21, 1986, and payments by eligible organizations or entities occurring on or after April 1, 1991*.

*P.L. 100-203, §4016, changed "1989" to "1990", effective December 22, 1987.

P.L. 101-239, §6207(a), struck out "1990" and substituted "1991", effective December 19, 1989.

(1)(A) In the case of amounts recovered arising out of a claim under title XIX, there shall be paid to the State agency an amount bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State agency for such claim bears to the total amount paid for such claim.

(B) In the case of amounts recovered arising out of a claim under an allotment to a State under title V, there shall be paid to the State agency an amount equal to three-sevenths of the amount recovered.

(2) Such portion of the amounts recovered as is determined to have been paid out of the trust funds under sections 1817 and 1841 shall be repaid to such trust funds.

(3) The remainder of the amounts recovered shall be deposited as miscellaneous receipts of the Treasury of the United States.

The amount of such penalty or assessment, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States or a State agency to the person against whom the penalty or assessment has been assessed.

(g)[58] A determination by the Secretary to impose a penalty, assessment, or exclusion under subsection (a) or (b)[59] shall be final upon the expiration of the sixty-day period referred to in subsection (e). Matters that were raised or that could have been raised in a hearing before the Secretary or in an appeal pursuant to subsection (e)[60] may not be raised as a defense to a civil action by the United States to collect a penalty, assessment, or exclusion assessed under this section.

(h)[61] Whenever the Secretary's determination to impose a penalty, assessment, or exclusion under subsection (a) or (b)[62] becomes final, he shall notify the appropriate State or local medical or professional organization, the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1128(h)), and the appropriate utilization and quality control peer review organization, and the appropriate State or local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33)) that such a penalty, assessment, or exclusion has become final and the reasons therefor.

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[58] P.L. 99-509, §9313(c)(1)(D), redesignated the former subsection (f) as subsection (g), applicable to payments by hospitals occurring more than 6 months after October 21, 1986, and payments by eligible organizations or entities occurring on or after April 1, 1991*.

*P.L. 100-203, §4016, changed "1989" to "1990", effective December 22, 1987.

P.L. 101-239, §6207(a), struck out "1990" and substituted "1991", effective December 19, 1989.

[59] P.L. 99-509, §9313(c)(1)(A), inserted "or (b)", applicable to payments by hospitals occurring more than 6 months after October 21, 1986, and payments by eligible organizations or entities occurring on or after April 1, 1991*.

*P.L. 100-203, §4016, changed "1989" to "1990", effective December 22, 1987.

P.L. 101-239, §6207(a), struck out "1990" and substituted "1991", effective December 19, 1989.

[60] P.L. 99-509, §9313(c)(1)(C), struck out "(d)" and substituted "(e)", applicable to payments by hospitals occurring more than 6 months after October 21, 1986, and payments by eligible organizations or entities occurring on or after April 1, 1991*.

*P.L. 100-203, §4016, changed "1989" to "1990", effective December 22, 1987.

P.L. 101-239, §6207(a), struck out "1990" and substituted "1991", effective December 19, 1989.

[61] P.L. 99-509, §9313(c)(1)(D), redesignated the former subsection (g) as subsection (h), applicable to payments by hospitals occurring more than 6 months after October 21, 1986, and payments by eligible organizations or entities occurring on or after April 1, 1991*.

*P.L. 100-203, §4016, changed "1989" to "1990", effective December 22, 1987.

P.L. 101-239, §6207(a), struck out "1990" and substituted "1991", effective December 19, 1989.

[62] P.L. 99-509, §9313(c)(1)(A), inserted "or (b)", applicable to payments by hospitals occurring more than 6 months after October 21, 1986, and payments by eligible organizations or entities occurring on or after April 1, 1991*.

*P.L. 100-203, §4016, changed "1989" to "1990", effective December 22, 1987.

P.L. 101-239, §6207(a), struck out "1990" and substituted "1991", effective December 19, 1989.

(i)[63] For the purposes of this section:

(1) The term "State agency" means the agency established or designated to administer or supervise the administration of the State plan under title XIX of this Act or designated to administer the State's program under title V or title XX of this Act.

(2) The term "claim" means an application for payments for items and services under title V, XVIII, XIX, or XX of this Act.

(3) The term "item or service" includes (A) any particular item, device, medical supply, or service claimed to have been provided to a patient and listed in an itemized claim for payment, and (B) in the case of a claim based on costs, any entry in the cost report, books of account or other documents supporting such claim.

(4) The term "agency of the United States" includes any contractor acting as a fiscal intermediary, carrier, or fiscal agent or any other claims processing agent for a health insurance or medical services program under title XVIII or XIX of this Act.

(5) The term "beneficiary" means an individual who is eligible to receive items or services for which payment may be made under title V, XVIII, XIX, or XX but does not include a provider, supplier, or practitioner.

(j)(1)[64] The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may delegate the authority granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.

(2) The Secretary may delegate authority granted under this section and under section 1128 to the Inspector General of the Department of Health and Human Services.[65]

(k) Whenever the Secretary has reason to believe that any person has engaged, is engaging, or is about to engage in any activity which makes the person subject to a civil monetary penalty under this section, the Secretary may bring an action in an appropriate district court of the United States (or, if applicable, a United States court of any territory) to enjoin such activity, or to enjoin the person from concealing, removing, encumbering, or disposing of assets which may be required in order to pay a civil monetary penalty if any such penalty were to be imposed or to seek other appropriate relief.

(l) A principal is liable for penalties, assessments, and an exclusion under this section for the actions of the principal's agent acting within the scope of the agency.

CRIMINAL PENALTIES FOR ACTS INVOLVING MEDICARE OR STATE HEALTH CARE PROGRAMS[66]

SEC. 1128B. [42 U.S.C. 1320a-7b] (a) Whoever—

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[63] P.L. 99-509, §9313(c)(1)(D), redesignated the former subsection (h) as subsection (i), applicable to payments by hospitals occurring more than 6 months after October 21, 1986, and payments by eligible organizations or entities occurring on or after April 1, 1991[*].

[*] P.L. 100-203, §4016, changed "1989" to "1990", effective December 22, 1987.

P.L. 101-239, §6207(a), struck out "1990" and substituted "1991", effective December 19, 1989.

[64] P.L. 101-508, §4027(sic)(h)(i), struck out "(j)" and substituted "(j)(1)", effective November 5, 1990.

P.L. 101-508, §4753(1), made the same amendment.

[65] P.L. 101-508, §4027(sic)(h)(ii), added paragraph (2), effective November 5, 1990.

P.L. 101-508, §4753(2), made the same amendment.

[66] See Vol. II, 18 U.S.C. 1028 and 1738, with respect to penalties relating to use of identification documents.

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a program under title XVIII or a State health care program (as defined in section 1128(h)),

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized,

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person, or

(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a program under title XVIII or a State health care program and knows that the individual who furnished the service was not licensed as a physician,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under title XIX is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of that title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under title XVIII or a State health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under title XVIII or a State health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under title XVIII or a State health care program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under title XVIII or a State health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under title XVIII or a State health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under title XVIII or a State health care program;

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services;

(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under title XVIII or a State health care program if—

(i) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such individual or entity under the contract, and

(ii) in the case of an entity that is a provider of services (as defined in section 1861(u)), the person discloses (in such form and manner as the Secretary requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity;[67]

(D) a waiver of any coinsurance under part B of title XVIII by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act[68]; and[69]

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[67] P.L. 101-508, §4161(a)(4)(A), struck out "and".

[68] P.L. 78-410.

(E)[70] any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987.[71]

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon recertification) as a hospital, rural primary care hospital,[72] skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded[73], home health agency, or other entity (including an eligible organization under section 1876(b)) for which certification is required under title XVIII or a State health care program, or with respect to information required to be provided under section 1124A,[74] shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully—

(1) charges, for any service provided to a patient under a State plan approved under title XIX, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under title XIX, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—

(A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded[75], or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(e) Whoever accepts assignments described in section 1842(b)(3)(B)(ii) or agrees to be a participating physician or supplier under section 1842(h)(1) and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than six months, or both.

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[69] P.L. 101-508, §4161(a)(4)(C), added this subparagraph (D), applicable to services furnished on or after October 1, 1991, except as provided in P.L. 101-508, §4161(a)(8)(B), in Vol. II.

[70] P.L. 101-508, §4161(a)(4)(B), redesignated subparagraph (D) as subparagraph (E).

[71] See Vol. II, P.L. 100-93, §14(a), with respect to standards for anti-kickback provisions.

[72] P.L. 101-239, §6003(g)(3)(D)(ii), inserted "rural primary care hospital,", effective December 19, 1989.

[73] P.L. 100-203, §4211(h)(7)(A), struck out "intermediate care facility" and substituted "nursing facility, intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[74] P.L. 101-508, §4164(b)(2), inserted ", or with respect to information required to be provided under section 1124A,". For the effective date, see Vol. II, P.L. 101-508, §4164(b)(4).

[75] P.L. 100-203, §4211(h)(7)(B), struck out "skilled nursing facility, or intermediate care facility" and substituted "nursing facility, or intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[SEC. 1129. Repealed.[76]]

[SEC. 1130. Repealed.[77]]

NOTIFICATION OF SOCIAL SECURITY CLAIMANT WITH RESPECT TO DEFERRED VESTED BENEFITS[78]

SEC. 1131. [42 U.S.C. 1320b-1] (a) Whenever—

(1) the Secretary makes a finding of fact and a decision as to—

(A) the entitlement of any individual to monthly benefits under section 202, 223, or 228,

(B) the entitlement of any individual to a lump-sum death payment payable under section 202(i) on account of the death of any person to whom such individual is related by blood, marriage, or adoption, or

(C) the entitlement under section 226 of any individual to hospital insurance benefits under part A of title XVIII, or

(2) the Secretary is requested to do so—

(A) by any individual with respect to whom the Secretary holds information obtained under section 6057 of the Internal Revenue Code of 1954[79], or

(B) in the case of the death of the individual referred to in subparagraph (A), by the individual who would be entitled to payment under section 204(d) of this Act,

he shall transmit to the individual referred to in paragraph (1) or the individual making the request under paragraph (2) any information, as reported by the employer, regarding any deferred vested benefit transmitted to the Secretary pursuant to such section 6057 with respect to the individual referred to in paragraph (1) or (2)(A) or the person on whose wages and self-employment income entitlement (or claim of entitlement) is based.

(b)(1) For purposes of section 201(g)(1), expenses incurred in the administration of subsection (a) shall be deemed to be expenses incurred for the administration of title II.

(2) There are hereby authorized to be appropriated to the Federal Old-Age and Survivors Insurance Trust Fund for each fiscal year (commencing with the fiscal year ending June 30, 1974) such sums as the Secretary deems necessary on account of additional administrative expenses resulting from the enactment of the provisions of subsection (a).

PERIOD WITHIN WHICH CERTAIN CLAIMS MUST BE FILED[80]

SEC. 1132. [42 U.S.C. 1320b-2] (a) Notwithstanding any other provision of this Act (but subject to subsection (b)), any claim by a State for payment with respect to an expenditure made during any calendar quarter by the State—

(1) in carrying out a State plan approved under title I, IV, X, XIV, XVI, XIX, or XX of this Act, or

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[76] P.L. 100-203, §4118(m)(1)(A); 101 Stat. 1330-157.

[77] P.L. 93-647, §3(e)(1); 88 Stat. 2349.

[78] See Vol. II, P.L. 83-591, §6103(l), relating to disclosure of returns and return information by the Secretary of the Treasury to the Social Security Administration, and §7213(a)(1) relating to the penalty for unauthorized disclosure of that tax return information.

[79] P.L. 83-591.

[80] See Vol. II, P.L. 96-272, §306, with respect to the time limits for certain claims for expenditures.

(2) under any other provision of this Act which provides (on an entitlement basis) for Federal financial participation in expenditures made under State plans or programs,

shall be filed (in such form and manner as the Secretary shall by regulations prescribe) within the two-year period which begins on the first day of the calendar quarter immediately following such calendar quarter; and payment shall not be made under this Act on account of any such expenditure if claim therefor is not made within such two-year period; except that this subsection shall not be applied so as to deny payment with respect to any expenditure involving court-ordered retroactive payments or audit exceptions, or adjustments to prior year costs.

(b) The Secretary shall waive the requirement imposed under subsection (a) with respect to the filing of any claim if he determines (in accordance with regulations) that there was good cause for the failure by the State to file such claim within the period prescribed under subsection (a). Any such waiver shall be only for such additional period of time as may be necessary to provide the State with a reasonable opportunity to file such claim. A failure to file a claim within such time period which is attributable to neglect or administrative inadequacies shall be deemed not to be for good cause.

APPLICANTS OR RECIPIENTS UNDER PUBLIC ASSISTANCE PROGRAMS NOT TO BE REQUIRED TO MAKE ELECTION RESPECTING CERTAIN VETERANS' BENEFITS

SEC. 1133. [42 U.S.C. 1320b-3] (a) Notwithstanding any other provision of law (but subject to subsection (b)), no individual who is an applicant for or recipient of aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV, or of benefits under the Supplemental Security Income program established by title XVI shall—

(1) be required, as a condition of eligibility for (or of continuing to receive) such aid, assistance, or benefits, to make an election under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978[81] with respect to pension paid by the Veterans' Administration, or

(2) by reason of failure or refusal to make such an election, be denied (or suffer a reduction in the amount of) such aid, assistance, or benefits.

(b) The provisions of subsection (a) shall be applicable only with respect to an individual, who is an applicant for or recipient of aid, assistance, or benefits described in subsection (a), during a period with respect to which there is in effect—

(1) in case such individual is an applicant for or recipient of aid or assistance under a State plan referred to in subsection (a), in the State having such plan, or

(2) in case such individual is an applicant for or recipient of benefits under the Supplemental Security Income program established by title XVI, in the State in which the individual applies for or receives such benefits,

a State plan for medical assistance, approved under title XIX, under which medical assistance is available to such individual only for periods for which such individual is a recipient of aid, assistance, or benefits described in subsection (a).

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[81] P.L. 95-588.

NONPROFIT HOSPITAL PHILANTHROPY

SEC. 1134. [42 U.S.C. 1320b-4] For purposes of determining, under titles XVIII and XIX of this Act, the reasonable costs of services provided by nonprofit hospitals or rural primary care hospitals[82], the following items shall not be deducted from the operating costs of such hospitals or rural primary care hospitals[83]:

(1) A grant, gift, or endowment, or income therefrom, which is to or for such a hospital and which has not been designated by the donor for paying any specific operating costs.

(2) A grant or similar payment which is to such a hospital, which was made by a governmental entity, and which is not available under the terms of the grant or payment for use as operating funds.

(3) Those types of donor designated[84] grants and gifts (including grants and similar payments which are made by a governmental entity), and income therefrom, which the Secretary determines, in the best interests of needed health care, should be encouraged.

(4) The proceeds from the sale or mortgage of any real estate or other capital asset of such a hospital, which real estate or asset the hospital acquired through gift or grant, if such proceeds are not available for use as operating funds under the terms of the gift or grant.

Paragraph (4) shall not apply to the recovery of the appropriate share of depreciation when gains or losses are realized from the disposal of depreciable assets.

DEVELOPMENT OF MODEL PROSPECTIVE RATE METHODOLOGY

SEC. 1135. [42 U.S.C. 1320b-5] (a) The Secretary shall develop a model system or systems for the payment of hospitals for inpatient hospital services on a prospective basis which may be applied for reimbursement of hospitals under title XVIII or under a State plan approved under title XIX.

(b) The Secretary shall report to the Congress on the development of such system or systems not later than July 31, 1982.

(c) The Secretary shall develop, in consultation with the Senate Committee on Finance and the Committee on Ways and Means of the House of Representatives, proposals for legislation which would provide that hospitals, skilled nursing facilities, and, to the extent feasible, other providers, would be reimbursed under title XVIII of this Act on a prospective basis. The Secretary shall report such proposals to such committees not later than December 31, 1982.

(d)(1) The Secretary shall develop a fully prospective payment system for ambulatory surgical procedures performed on patients in hospitals on an outpatient basis.

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[82] P.L. 101-239, §6003(g)(3)(D)(iii), inserted "or rural primary care hospitals", effective December 19, 1989.

[83] P.L. 101-239, §6003(g)(3)(D)(iii), inserted "or rural primary care hospitals", effective December 19, 1989.

[84] As in original. Possibly should be "donor-designated".

(2) The system shall, to the extent practicable, provide for an all-inclusive payment rate for ambulatory surgical procedures performed on patients in hospitals on an outpatient basis, which rate encompasses payment for facility services and all medical and other health services, other than physicians' services, commonly furnished in connection with such procedures.

(3) The system shall provide for appropriate payment rates with respect to such procedures. In establishing such rates, the Secretary shall consider whether a differential payment rate is appropriate for specialty hospitals.

(4) Such rates shall take into account at least the following considerations:

(A) The costs of hospitals providing ambulatory surgical procedures.

(B) The costs under this title of payment for such procedures performed in ambulatory surgical centers.

(C) The extent to which any differences in such costs are justifiable.

(5) The Secretary shall submit to Congress—

(A) an interim report on the development of the system by April 1, 1988, and

(B) a final report on such system by April 1, 1989.

The report under subparagraph (B) shall include recommendations concerning the implementation of the payment system for ambulatory surgical procedures performed on or after October 1, 1989.

(6)(A) The Secretary shall develop a model system for the payment for outpatient hospital services other than ambulatory surgery.

(B) The Secretary shall submit to Congress a report on the model payment system under subparagraph (A) by January 1, 1991.

(7) The Secretary shall solicit the views of the Prospective Payment Assessment Commission in developing the systems under paragraphs (1) and (6), and shall include in the Secretary's reports under this subsection any views the Commission may submit with respect to such systems.

PILOT PROJECTS TO DEMONSTRATE THE USE OF INTEGRATED SERVICE DELIVERY SYSTEMS FOR HUMAN SERVICES PROGRAMS

SEC. 1136. [42 U.S.C. 1320b-6] (a) In order to develop and demonstrate ways of improving the delivery of services to individuals and families who need them under the various human services programs, by eliminating programmatic fragmentation and thereby assuring that an applicant for services under any one such program will be informed of and have access to all of the services which may be available to him or his family under the other human services programs being carried out in the community involved, any State having an approved plan under part A of title IV may, subject to the provisions of this section, establish and conduct one or more pilot projects to demonstrate the use of integrated service delivery systems for human services programs in that State or in one or more political subdivisions thereof.

(b) The integration of service delivery systems for human services programs in any State or locality under a pilot project established under this section shall involve or include—

(1) the development of a common set of terms for use in all of the human services programs involved;

(2) the development for each applicant of a single comprehensive family profile which is suitable for use under all of the human services programs involved;

(3) the establishment and maintenance of a single resources directory by which the citizens of the community involved may be informed of and gain access to the services which are available under all such programs;

(4) the development of a unified budget and budgeting process, and a unified accounting system, with standardized audit procedures;

(5) the implementation of unified planning, needs assessment, and evaluation;

(6) the consolidation of agency locations and related transportation services;

(7) the standardization of procedures for purchasing services from nongovernmental sources;

(8) the creation of communications linkages among agencies to permit the serving of individual and family needs across program and agency lines;

(9) the development, to the maximum extent possible, of uniform application and eligibility determination procedures; and

(10) any other methods, arrangements, and procedures which the Secretary determines are necessary or desirable for, and consistent with, the establishment and operation of an integrated service delivery system.

(c)(1) Any State which desires to establish and conduct a pilot project under this section, after having published a description of the proposed project and invited comments thereon from interested persons in the community or communities which would be affected, shall submit an application to the Secretary (in such form and containing such information as the Secretary may require) within 6 months after the date of the enactment of this section[85]. The proposed project may be statewide in operation or may be limited to one or more political subdivisions of the State; and the application shall in any event include or be accompanied by satisfactory assurances that the project as proposed would be permitted under applicable State and local law.

(2) The Secretary shall consider all applications and accompanying comments and materials which are submitted under paragraph (1), and, no later than 9 months after the date of the enactment of this section[86], shall approve no fewer than 3 nor more than 5 of the proposed projects (including one such project to be operated on a statewide basis). In considering and approving such applications the Secretary shall take into account the size and characteristics of the population that would be served by each proposed project, the desirability of wide geographic distribution among the projects, the number and nature of the human services programs which are in active operation in the various communities involved, and such other factors as may tend to indicate whether or not a particular proposed project would provide a useful and effective demonstration of the value of an integrated service delivery system. Each project approved

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[85] Enacted July 18, 1984. [P.L. 98-369, §2630; 98 Stat. 1137]

[86] Enacted July 18, 1984. [P.L. 98-369, §2630; 98 Stat. 1137]

under this paragraph shall be deemed for purposes of this section to begin on the first day of the month following the month in which the application with respect to such project is approved.

(3) The Secretary shall approve any application for a project under this section only after determining that the conduct of such project will not lower or restrict the levels of aid, assistance, benefits, or services, or the income or resource standards, deductions, or exclusions, under any of the human services programs involved, and will not delay the provision of aid, assistance, benefits, or services under any of such programs.

(d)(1) Any State whose application is approved under subsection (c) may submit to the Secretary a request for the waiver of any requirement which would otherwise apply with respect to the proposed project under any of the laws governing the human services programs to be included in the project; and—

(A) if the law involved is within the jurisdiction of the Secretary and authority to grant the waiver involved is otherwise available to the Secretary under this title, title IV, or any other provision of law, the Secretary shall approve such request upon a determination that the waiver is necessary for the project to provide a useful and effective demonstration of the value of an integrated service delivery system; and

(B) if the law involved is within the jurisdiction of a Federal agency other than the Department of Health and Human Services and authority to grant the waiver involved is available to the head of such other agency under that law or any other provision of law, the Secretary shall transmit such request (on behalf of the requesting State) to the head of such other agency, who shall approve such request upon a determination that the waiver is necessary for the project to provide a useful and effective demonstration of the value of an integrated service delivery system and who shall certify such approval to the Secretary.

(2) If under the law governing any of the human services programs included within a project there are provisions establishing safeguards which limit or restrict the use or disclosure of information (concerning applicants for or recipients of benefits or services) which has been obtained or developed by the agency involved in the conduct of that program, and a waiver of such provisions is granted under paragraph (1) in order to make such information available for purposes of the project—

(A) the State shall provide each applicant for and recipient of aid, assistance, benefits, or services under the proposed integrated service delivery system with a clear and readily comprehensible notice that such information may be disclosed to and used by project personnel, or exchanged with the other agencies having responsibility for human services programs included within the project;

(B) the State shall take such steps as may be necessary to ensure that the information disclosed will be used only for purposes of, and by persons directly connected with, such project; and

(C) the State's application with respect to the project under subsection (c) shall contain or be accompanied by satisfactory assurances that the preceding requirements of this paragraph will be fully complied with.

(e) The Secretary shall from time to time pay to each State which has an approved pilot project under this section, in such manner and according to such schedule as may be agreed upon by the Secretary and such State, amounts equal in the aggregate to—

(1) 90 percent of the costs incurred by such State and its political subdivisions in carrying out such project during the first 18 months after the date on which the project begins,

(2) 80 percent of any such costs incurred during the 12-month period beginning with the nineteenth month after such date, and

(3) 70 percent of any such costs incurred during the 12-month period beginning with the thirty-first month after such date.

(f)(1) For purposes of this section, the term "human services program" includes the program of aid to families with dependent children under part A of title IV, the supplemental security income benefits program under title XVI, the Federal food stamp program, and any other Federal or federally assisted program (other than a program under the Rehabilitation Act of 1973[87]) which provides aid, assistance, or benefits based wholly or partly on need or on income-related qualifications to specified classes or types of individuals or families or which is designed to help in crisis or emergency situations by meeting the basic human needs of individuals or families whose own resources are insufficient for that purpose.

(2) In carrying out this section the Secretary shall regularly consult with the Secretary of Labor, the Secretary of Agriculture, the Secretary of Housing and Urban Development, and the head of any other Federal agency having jurisdiction over or responsibility for one or more human services programs, in order to ensure that the administrative efforts of the various agencies involved are coordinated with respect to all of the pilot projects being carried out under this section.

(g) The Secretary shall require each State which is carrying out a pilot project under this section to submit periodic reports on the progress of such project, giving particular attention to the cost-effectiveness of the integrated service delivery system involved and the extent to which such system is improving the delivery of services. No pilot project under this section shall be conducted for a period of longer than 42 months. The first such report shall be submitted no later than 3 months after the date on which the project begins.

(h) The Secretary shall from time to time submit to the Congress a report on the progress and current status of each of the approved pilot projects under this section. Each such report shall reflect the periodic reports theretofore submitted to the Secretary by the States involved under subsection (g), and shall contain such additional comments, findings, and recommendations with respect to the operation of the program under this section as the Secretary may determine to be appropriate.

(i) The Comptroller General shall, at such time or times as he determines to be appropriate, review and evaluate any or all of the pilot projects undertaken pursuant to this section, and shall from time to time report to the Congress on the results of such reviews and evaluations together with his findings and recommendations with respect thereto.

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[87] P.L. 93-112.

(j) There are authorized to be appropriated, for the four-fiscal-year period beginning with the fiscal year 1985, such sums, not to exceed $8,000,000 in the aggregate, as may be necessary to carry out this section.

INCOME AND ELIGIBILITY VERIFICATION SYSTEM

SEC. 1137. [42 U.S.C. 1320b-7] (a) In order to meet the requirements of this section, a State must have in effect an income and eligibility verification system which meets the requirements of subsection (d) and under which—

(1) the State shall require, as a condition of eligibility for benefits under any program listed in subsection (b), that each applicant for or recipient of benefits under that program furnish to the State his social security account number (or numbers, if he has more than one such number), and the State shall utilize such account numbers in the administration of that program so as to enable the association of the records pertaining to the applicant or recipient with his account number;

(2) wage information from agencies administering State unemployment compensation laws available pursuant to section 3304(a)(16) of the Internal Revenue Code of 1954[88], wage information reported pursuant to paragraph (3) of this subsection, and wage, income, and other information from the Social Security Administration and the Internal Revenue Service available pursuant to section 6103(l)(7) of such Code, shall be requested and utilized to the extent that such information may be useful in verifying eligibility for, and the amount of, benefits available under any program listed in subsection (b), as determined by the Secretary of Health and Human Services (or, in the case of the unemployment compensation program, by the Secretary of Labor, or, in the case of the food stamp program, by the Secretary of Agriculture);

(3) employers in such State are required, effective September 30, 1988, to make quarterly wage reports to a State agency (which may be the agency administering the State's unemployment compensation law) except that the Secretary of Labor (in consultation with the Secretary of Health and Human Services and the Secretary of Agriculture) may waive the provisions of this paragraph if he determines that the State has in effect an alternative system which is as effective and timely for purposes of providing employment related income and eligibility data for the purposes described in paragraph (2);

(4) the State agencies administering the programs listed in subsection (b) adhere to standardized formats and procedures established by the Secretary of Health and Human Services (in consultation with the Secretary of Agriculture) under which—

(A) the agencies will exchange with each other information in their possession which may be of use in establishing or verifying eligibility or benefit amounts under any other such program;

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[88] P.L. 83-591.

(B) such information shall be made available to assist in the child support program under part D of title IV of this Act, and to assist the Secretary of Health and Human Services in establishing or verifying eligibility or benefit amounts under titles II and XVI of this Act, but subject to the safeguards and restrictions established by the Secretary of the Treasury with respect to information released pursuant to section 6103(l) of the Internal Revenue Code of 1954; and[89]

(C) the use of such information shall be targeted to those uses which are most likely to be productive in identifying and preventing ineligibility and incorrect payments, and no State shall be required to use such information to verify the eligibility of all recipients;

(5) adequate safeguards are in effect so as to assure that—

(A) the information exchanged by the State agencies is made available only to the extent necessary to assist in the valid administrative needs of the program receiving such information, and the information released pursuant to section 6103(l) of the Internal Revenue Code of 1954 is only exchanged with agencies authorized to receive such information under such section 6103(l); and[90]

(B) the information is adequately protected against unauthorized disclosure for other purposes, as provided in regulations established by the Secretary of Health and Human Services, or, in the case of the unemployment compensation program, the Secretary of Labor, or, in the case of the food stamp program, the Secretary of Agriculture, or in the case of information released pursuant to section 6103(l) of the Internal Revenue Code of 1954[91], the Secretary of the Treasury;[92]

(6) all applicants for and recipients of benefits under any such program shall be notified at the time of application, and periodically thereafter, that information available through the system will be requested and utilized; and

(7) accounting systems are utilized which assure that programs providing data receive appropriate reimbursement from the programs utilizing the data for the costs incurred in providing the data.

(b) The programs which must participate in the income and eligibility verification system are—

(1) the aid to families with dependent children program under part A of title IV of this Act;

(2) the medicaid program under title XIX of this Act;

(3) the unemployment compensation program under section 3304 of the Internal Revenue Code of 1954;

(4) the food stamp program under the Food Stamp Act of 1977[93]; and

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[89] See Vol. II, P.L. 100-203, §9402(b), with respect to the Congressional intent of P.L. 83-591, §6103(l)(10) (added by P.L. 98-369).

[90] See Vol. II, P.L. 100-203, §9402(b), with respect to the Congressional intent of P.L. 83-591, §6103(l)(10) (added by P.L. 98-369).

[91] P.L. 83-591.

[92] See Vol. II, P.L. 100-203, §9402(b), with respect to the Congressional intent of P.L. 83-591, §6103(l)(10) (added by P.L. 98-369).

[93] P.L. 88-525.

(5) any State program under a plan approved under title I, X, XIV, or XVI of this Act.

(c)(1) In order to protect applicants for and recipients of benefits under the programs identified in subsection (b), or under the supplemental security income program under title XVI, from the improper use of information obtained from the Secretary of the Treasury under section 6103(l)(7)(B) of the Internal Revenue Code of 1954, no Federal, State, or local agency receiving such information may terminate, deny, suspend, or reduce any benefits of an individual until such agency has taken appropriate steps to independently verify information relating to—

(A) the amount of the asset or income involved,

(B) whether such individual actually has (or had) access to such asset or income for his own use, and

(C) the period or periods when the individual actually had such asset or income.

(2) Such individual shall be informed by the agency of the findings made by the agency on the basis of such verified information, and shall be given an opportunity to contest such findings, in the same manner as applies to other information and findings relating to eligibility factors under the program.

(d) The requirements of this subsection, with respect to an income and eligibility verification system of a State, are as follows:

(1)(A) The State shall require, as a condition of an individual's eligibility for benefits under any program listed in subsection (b), a declaration in writing by the individual (or, in the case of an individual who is a child, by another on the individual's behalf), under penalty of perjury, stating whether or not the individual is a citizen or national of the United States, and, if that individual is not a citizen or national of the United States, that the individual is in a satisfactory immigration status.

(B) In this subsection—

(i) in the case of the program described in subsection (b)(1), any reference to an individual's eligibility for benefits under the program shall be considered a reference to the individual's being considered a dependent child or to the individual's being treated as a caretaker relative or other person whose needs are to be taken into account in making the determination under section 402(a)(7),

(ii) in the case of the program described in subsection (b)(4)—

(I) any reference to the State shall be considered a reference to the State agency, and

(II) any reference to an individual's eligibility for benefits under the program shall be considered a reference to the individual's eligibility to participate in the program as a member of a household, and

(III) the term "satisfactory immigration status" means an immigration status which does not make the individual ineligible for benefits under the applicable program.

(2) If such an individual is not a citizen or national of the United States, there must be presented either—

(A) alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual's alien admission number or alien file number (or numbers if the individual has more than one number), or

(B) such other documents as the State determines constitutes reasonable evidence indicating a satisfactory immigration status.

(3) If the documentation described in paragraph (2)(A) is presented, the State shall utilize the individual's alien file or alien admission number to verify with the Immigration and Naturalization Service the individual's immigration status through an automated or other system (designated by the Service for use with States) that—

(A) utilizes the individual's name, file number, admission number, or other means permitting efficient verification, and

(B) protects the individual's privacy to the maximum degree possible.

(4) In the case of such an individual who is not a citizen or national of the United States, if, at the time of application for benefits, the statement described in paragraph (1) is submitted but the documentation required under paragraph (2) is not presented or if the documentation required under paragraph (2)(A) is presented but such documentation is not verified under paragraph (3)—

(A) the State—

(i) shall provide a reasonable opportunity to submit to the State evidence indicating a satisfactory immigration status, and

(ii) may not delay, deny, reduce, or terminate the individual's eligibility for benefits under the program on the basis of the individual's immigration status until such a reasonable opportunity has been provided; and

(B) if there are submitted documents which the State determines constitutes reasonable evidence indicating such status—

(i) the State shall transmit to the Immigration and Naturalization Service photostatic or other similar copies of such documents for official verification,

(ii) pending such verification, the State may not delay, deny, reduce, or terminate the individual's eligibility for benefits under the program on the basis of the individual's immigration status, and

(iii) the State shall not be liable for the consequences of any action, delay, or failure of the Service to conduct such verification.

(5) If the State determines, after complying with the requirements of paragraph (4), that such an individual is not in a satisfactory immigration status under the applicable program—

(A) the State shall deny or terminate the individual's eligibility for benefits under the program, and

(B) the applicable fair hearing process shall be made available with respect to the individual.

(e) Each Federal agency responsible for administration of a program described in subsection (b) shall not take any compliance, disallowance, penalty, or other regulatory action against a State with respect to any error in the State's determination to make an individual eligible for benefits based on citizenship or immigration status—

(1) if the State has provided such eligibility based on a verification of satisfactory immigration status by the Immigration and Naturalization Service,

(2) because the State, under subsection (d)(4)(A)(ii), was required to provide a reasonable opportunity to submit documentation,

(3) because the State, under subsection (d)(4)(B)(ii), was required to wait for the response of the Immigration and Naturalization Service to the State's request for official verification of the immigration status of the individual, or

(4) because of a fair hearing process described in subsection (d)(5)(B).

(f) Subsections (a)(1) and (d) shall not apply with respect to aliens seeking medical assistance for the treatment of an emergency medical condition under section 1903(v)(2).

HOSPITAL PROTOCOLS FOR ORGAN PROCUREMENT AND STANDARDS FOR ORGAN PROCUREMENT AGENCIES

SEC. 1138. [42 U.S.C. 1320b-8] (a)(1) The Secretary shall provide that a hospital or rural primary care hospital[94] meeting the requirements of title XVIII or XIX may participate in the program established under such title only if—

(A) the hospital or rural primary care hospital[95] establishes written protocols for the identification of potential organ donors that—

(i) assure that families of potential organ donors are made aware of the option of organ or tissue donation and their option to decline,

(ii) encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of such families, and

(iii) require that an organ procurement agency designated by the Secretary pursuant to subsection (b)(1)(F) be notified of potential organ donors; and

(B) in the case of a hospital in which organ transplants are performed, the hospital is a member of, and abides by the rules and requirements of, the Organ Procurement and Transplantation Network established pursuant to section 372 of the Public Health Service Act[96] (in this section referred to as the "Network").

(2) For purposes of this subsection, the term "organ" means a human kidney, liver, heart, lung, pancreas, and any other human organ or tissue specified by the Secretary for purposes of this subsection.

(b)(1) The Secretary shall provide that payment may be made under title XVIII or XIX with respect to organ procurement costs attributable to payments made to an organ procurement agency only if the agency—

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[94] P.L. 101-239, §6003(g)(3)(D)(iv), inserted "or rural primary care hospital", effective December 19, 1989.

[95] P.L. 101-239, §6003(g)(3)(D)(iv), inserted "or rural primary care hospital", effective December 19, 1989.

[96] P.L. 78-410.

(A)(i) is a qualified organ procurement organization (as described in section 371(b) of the Public Health Service Act) that is operating under a grant made under section 371(a) of such Act. or (ii) has been certified or recertified by the Secretary within the previous two years as meeting the standards to be a qualified organ procurement organization (as so described);

(B) meets the requirements that are applicable under such title for organ procurement agencies;

(C) meets performance-related standards prescribed by the Secretary;

(D) is a member of, and abides by the rules and requirements of, the Network;

(E) allocates organs, within its service area and nationally, in accordance with medical criteria and the policies of the Network; and

(F) is designated by the Secretary as an organ procurement organization payments to which may be treated as organ procurement costs for purposes of reimbursement under such title.

(2) The Secretary may not designate more than one organ procurement organization for each service area (described in section 371(b)(1)(E) of the Public Health Service Act) under paragraph (1)(F).[97]

NATIONAL COMMISSION ON CHILDREN

SEC. 1139. [42 U.S.C. 1320b-9] (a)(1) There is hereby established a commission to be known as the National Commission on Children (in this section referred to as the "Commission").

(b)(1) The Commission shall consist of—

(A) 12 members to be appointed by the President,

(B) 12 members to be appointed by the Speaker of the House of Representatives, and

(C) 12 members to be appointed by the President pro tempore of the Senate.

(2) The President, the Speaker, and the President pro tempore shall each appoint as members of the Commission—

(A) 4 individuals who—

(i) are representatives of organizations providing services to children,

(ii) are involved in activities on behalf of children, or

(iii) have engaged in academic research with respect to the problems and needs of children,

(B) 4 individuals who are elected or appointed public officials (at the Federal, State, or local level) involved in issues and programs relating to children, and

(C) 4 individuals who are parents or representatives of parents or parents' organizations.

(3) The appointments made pursuant to subparagraphs (B) and (C) of paragraph (1) shall be made in consultation with the chairmen of committees of the House of Representatives and the Senate, respectively, having jurisdiction over relevant Federal programs.

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[97] P.L. 101-274, provides that P.L. 78-410, §371(b)(1)(E) [as amended by P.L. 100-607, §402(c)(1)(A)], shall not apply to an organ procurement organization designated under this subsection until January 1, 1992.

(c)(1) It shall be the duty and function of the Commission to serve as a forum on behalf of the children of the Nation and to conduct the studies and issue the report required by subsection (d).

(2) The Commission (and any committees that it may form) shall conduct public hearings in different geographic areas of the country, both urban and rural, in order to receive the views of a broad spectrum of the public on the status of the Nation's children and on ways to safeguard and enhance the physical, mental, and emotional well-being of all of the children of the Nation, including those with physical or mental disabilities, and others whose circumstances deny them a full share of the opportunities that parents of the Nation may rightfully expect for their children.

(3) The Commission shall receive testimony from individuals, and from representatives of public and private organizations and institutions with an interest in the welfare of children, including educators, health care professionals, religious leaders, providers of social services, representatives of organizations with children as members, elected and appointed public officials, and from parents and children speaking in their own behalf.

(d) The Commission shall submit to the President, and to the Committees on Finance and Labor and Human Resources of the Senate and the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives, an interim report no later than September 30, 1990[98], and a final report no later than March 31, 1991[99], setting forth recommendations with respect to the following subjects:

(1) Questions relating to the health of children that the Commission shall address include—

(A) how to reduce infant mortality,

(B) how to reduce the number of low-birth-weight babies,

(C) how to reduce the number of children with chronic illnesses and disabilities,

(D) how to improve the nutrition of children,

(E) how to promote the physical fitness of children,

(F) how to ensure that pregnant women receive adequate prenatal care,

(G) how to ensure that all children have access to both preventive and acute care health services, and

(H) how to improve the quality and availability of health care for children.

(2) Questions relating to social and support services for children and their parents that the Commission shall address include—

(A) how to prevent and treat child neglect and abuse,

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[98] P.L. 100-647, §8201(1), struck out "September 30, 1988" and substituted "March 31, 1990", effective November 10, 1988.

P.L. 101-239, §6221(1)(A), made the same amendment, effective December 19, 1989.

P.L. 101-508, §4027(sic)(k)(6), in effect, struck out "March 31, 1990" and substituted "March 31, 1990", effective November 5, 1990.

P.L. 101-508, §5057, struck out "March 31, 1991(sic)" and substituted "September 30, 1990", effective November 5, 1990.

[99] P.L. 100-647, §8201(2), struck out "March 31, 1989" and substituted "September 30, 1990", effective November 10, 1988.

P.L. 101-239, §6221(1)(B), struck out "March 31, 1990" and substituted "March 31, 1991", effective December 19, 1989.

P.L. 101-508, §4027(sic)(k)(6), in effect, struck out "March 31, 1991" and substituted "March 31, 1991", effective November 5, 1990.

P.L. 101-508, §5057, struck out "September 30, 1990" and substituted "March 31, 1991", effective November 5, 1990.

(B) how to provide help to parents who seek assistance in meeting the problems of their children,

(C) how to provide counseling services for children,

(D) how to strengthen the family unit,

(E) how children can be assured of adequate care while their parents are working or participating in education or training programs,

(F) how to improve foster care and adoption services,

(G) how to reduce drug and alcohol abuse by children and youths, and

(H) how to reduce the incidence of teenage pregnancy.

(3) Questions relating to education that the Commission shall address include—

(A) how to encourage academic excellence for all children at all levels of education,

(B) how to use preschool experiences to enhance educational achievement,

(C) how to improve the qualifications of teachers,

(D) how schools can better prepare the Nation's youth to compete in the labor market,

(E) how parents and schools can work together to help children achieve success at each step of the academic ladder,

(F) how to encourage teenagers to complete high school and remain in school to fulfill their academic potential,

(G) how to address the problems of drug and alcohol abuse by young people,

(H) how schools might lend support to efforts aimed at reducing the incidence of teenage pregnancy, and

(I) how schools might better meet the special needs of children who have physical or mental handicaps.

(4) Questions relating to income security that the Commission shall address include—

(A) how to reduce poverty among children,

(B) how to ensure that parents support their children to the fullest extent possible through improved child support collection services, including services on behalf of children whose parents are unmarried, and

(C) how to ensure that cash assistance to needy children is adequate.

(5) Questions relating to tax policy that the Commission shall address include—

(A) how to assure the equitable tax treatment of families with children,

(B) the effect of existing tax provisions, including the dependent care tax credit, the earned income tax credit, and the targeted jobs tax credit, on children living in poverty,

(C) whether the dependent care tax credit should be refundable and the effect of such a policy,

(D) whether the earned income tax credit should be adjusted for family size and the effect of such a policy, and

(E) whether there are other tax-related policies which would reduce poverty among children.

(6) In addition to addressing the questions specified in paragraphs (1) through (5), the Commission shall—

(A) seek to identify ways in which public and private organizations and institutions can work together at the community level to identify deficiencies in existing services for families and children and to develop recommendations to ensure that the needs of families and children are met, using all available resources, in a coordinated and comprehensive manner, and

(B) assess the existing capacities of agencies to collect and analyze data on the status of children and on relevant programs, identify gaps in the data collection system, and recommend ways to improve the collection of data and the coordination among agencies in the collection and utilization of data.

The reports required by this subsection shall be based upon the testimony received in the hearings conducted pursuant to subsection (c), and upon other data and findings developed by the Commission.

(e)(1)(A) Members of the Commission shall first be appointed not later than 60 days after the date of the enactment of this section[100], for terms ending on March 31, 1991[101].

(B) A vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the vacant position was first filled.

(2) The Commission shall elect one of its members to serve as Chairman of the Commission. The Chairman shall be a nonvoting member of the Commission.

(3) A majority of the members of the Commission shall constitute a quorum for the transaction of business.

(4)(A) The Commission shall meet at the call of the Chairman, or at the call of a majority of the members of the Commission.

(B) The Commission shall meet not less than 4 times during the period beginning with the date of the enactment of this section[102] and ending with September 30, 1990.

(5) Decisions of the Commission shall be according to the vote of a simple majority of those present and voting at a properly called meeting.

(6) Members of the Commission shall serve without compensation, but shall be reimbursed for travel, subsistence, and other necessary expenses incurred in the performance of their duties as members of the Commission.

(f)(1) The Commission shall appoint an Executive Director of the Commission. In addition to the Executive Director, the Commission may appoint and fix the compensation of such personnel as it deems advisable. Such appointments and compensation may be made without regard to title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(2) The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.[103]

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[100] This section was enacted December 22, 1987. [P.L. 100-203; 101 Stat. 1330-316]

[101] P.L. 101-239, §6221(2), struck out "September 30, 1990" and substituted "March 31, 1991", effective December 19, 1989.

[102] This section was enacted December 22, 1987. [P.L. 100-203; 101 Stat. 1330-316]

[103] P.L. 101-45, §409, amended subsection (f) in its entirety, effective June 30, 1989.

(g) In carrying out its duties, the Commission, or any duly organized committee thereof, is authorized to hold such hearings, sit and act at such times and places, and take such testimony, with respect to matters for which it has a responsibility under this section, as the Commission or committee may deem advisable.

(h)(1) The Commission may secure directly from any department or agency of the United States such data and information as may be necessary to carry out its responsibilities.

(2) Upon request of the Commission, any such department or agency shall furnish any such data or information.

(i) The General Services Administration shall provide to the Commission, on a reimbursable basis, such administrative support services as the Commission may request.

(j) There are authorized to be appropriated through fiscal year 1991,[104] such sums as may be necessary to carry out this section for each of fiscal years 1989 and 1990.

(k)(1) The Commission is authorized to accept donations of money, property, or personal services. Funds received from donations shall be deposited in the Treasury in a separate fund created for this purpose. Funds appropriated for the Commission and donated funds may be expended for such purposes as official reception and representation expenses, public surveys, public service announcements, preparation of special papers, analyses, and documentaries, and for such other purposes as determined by the Commission to be in furtherance of its mission to review national issues affecting children.

(2) For purposes of Federal income, estate, and gift taxation, money and other property accepted under paragraph (1) of this subsection shall be considered as a gift or bequest to or for the use of the United States.

(3) Expenditure of appropriated and donated funds shall be subject to such rules and regulations as may be adopted by the Commission and shall not be subject to Federal procurement requirements.[105]

(l) The Commission is authorized to conduct such public surveys as it deems necessary in support of its review of national issues affecting children and, in conducting such surveys, the Commission shall not be deemed to be an "agency" for the purpose of section 3502 of title 44, United States Code.[106]

PROHIBITION OF MISUSE OF SYMBOLS, EMBLEMS, OR NAMES IN REFERENCE TO SOCIAL SECURITY OR MEDICARE

SEC. 1140. [42 U.S.C. 1320b-10] (a) No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet, or other communication, or a play, motion picture, broadcast, telecast, or other production, alone or with other words, letters, symbols, or emblems—

(1) the words "Social Security", "Social Security Account", "Social Security System", "Social Security Administration", "Medicare", "Health Care Financing Administration", the letters "SSA" or "HCFA", or any other combination or variation of such words or letters, or

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[104] P.L. 101-239, §6221(3), inserted "through fiscal year 1991,", effective December 19, 1989.

[105] P.L. 101-239, §6221(4), added subsection (k), effective December 19, 1989.

[106] P.L. 101-239, §6221(4), added subsection (l), effective December 19, 1989.

(2) a symbol or emblem of the Social Security Administration (including the design of, or a reasonable facsimile of the design of, the social security card issued pursuant to section 205(c)(2)(E), the check used for payment of benefits under title II, or envelopes or other stationery used by the Social Security Administration) or of the Health Care Financing Administration, or any other combination or variation of such symbols or emblems,

in a manner which such person knows or should know would convey the false impression that such item is approved, endorsed, or authorized by the Social Security Administration, the Health Care Financing Administration, or the Department of Health and Human Services or that such person has some connection with, or authorization from, the Social Security Administration, the Health Care Financing Administration, or the Department of Health and Human Services.

(b)(1) Subject to paragraph (2), the Secretary may, pursuant to regulations, impose a civil money penalty not to exceed—

(A) except as provided in subparagraph (B), $5,000, or

(B) in the case of a violation consisting of a broadcast or telecast, $25,000,

against any person for each violation by such person of subsection (a).

(2) The total amount of penalties which may be imposed under paragraph (1) with respect to multiple violations in any one year period consisting of substantially identical communications or productions shall not exceed $100,000.

(c)(1) The provisions of section 1128A (other than subsections (a), (b), (f), (h), and (i)) shall apply to civil money penalties under subsection (b) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(2) Penalties imposed against a person under subsection (b) may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in the district court of the United States for the district in which the violation occurred or where the person resides, has its principal office, or may be found, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and shall be deposited as miscellaneous receipts of the Treasury of the United States. The amount of such penalty when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States to the person against whom the penalty has been imposed.

BLOOD DONOR LOCATOR SERVICE[107]

SEC. 1141. [42 U.S.C. 1320b-11] (a) IN GENERAL.—The Secretary shall establish and conduct a Blood Donor Locator Service, under the direction of the Commissioner of Social Security, which shall be used to obtain and transmit to any authorized person (as defined in subsection (h)(1)) the most recent mailing address of any blood donor who, as indicated by the donated blood or products derived therefrom or by the history of the subsequent use of such blood or blood products, has or may have the virus for acquired immune deficiency syndrome, in order to inform such donor of the possible need for medical care and treatment.

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[107] P.L. 100-647, §8008(b)(2), provides that the Secretary shall establish the Blood Donor Locator Service pursuant to this section not later than May 1, 1989.

(b) PROVISION OF ADDRESS INFORMATION.—Whenever the Secretary receives a request, filed by an authorized person (as defined in subsection (h)(1)), for the mailing address of a donor described in subsection (a) and the Secretary is reasonably satisfied that the requirements of this section have been met with respect to such request, the Secretary shall promptly undertake to provide the requested address information from—

(1) the files and records maintained by the Social Security Administration, and

(2) such files and records obtained pursuant to section 6103(m)(6) of the Internal Revenue Code of 1986[108] as the Secretary considers necessary to comply with such request.

(c) MANNER AND FORM OF REQUESTS.—A request for address information under this section shall be filed in such manner and form as the Secretary shall by regulation prescribe, shall include the blood donor's social security account number, and shall be accompanied or supported by such documents as the Secretary may determine to be necessary.

(d) PROCEDURES AND SAFEGUARDS.—Any authorized person shall, as a condition for receiving address information from the Blood Donor Locator Service—

(1) establish and maintain, to the satisfaction of the Secretary, a system for standardizing records with respect to any request, the reason for such request, and the date of such request made by or of it and any disclosure of address information made by or to it,

(2) establish and maintain, to the satisfaction of the Secretary, a secure area or place in which such address information and all related blood donor records shall be stored,

(3) restrict, to the satisfaction of the Secretary, access to the address information and related blood donor records only to persons whose duties or responsibilities require access and to whom disclosure may be made under the provisions of this section,

(4) provide such other safeguards which the Secretary determines (and which the Secretary prescribes in regulations) to be necessary or appropriate to protect the confidentiality of the address information and related blood donor records,

(5) furnish a report to the Secretary, at such time and containing such information as the Secretary may prescribe, which describes the procedures established and utilized by the authorized person for ensuring the confidentiality of address information and related blood donor records required under this subsection, and

(6) destroy such address information and related blood donor records, upon completion of their use in providing the notification for which the information was obtained, so as to make such information and records undisclosable.

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[108] P.L. 83-591.

If the Secretary determines that any authorized person has failed to, or does not, meet the requirements of this subsection, the Secretary may, after any proceedings for review established under subsection (f), take such actions as are necessary to ensure such requirements are met, including refusing to disclose address information to such authorized person until the Secretary determines that such requirements have been or will be met. In the case of any authorized person who discloses any address information received pursuant to this section or any related blood donor records to any agent, this subsection shall apply to such authorized person and each such agent (except that, in the case of an agent, any report to the Secretary or other action with respect to the Secretary shall be made or taken through such authorized person). The Secretary shall destroy all related blood donor records in the possession of the Department of Health and Human Services upon completion of their use in transmitting mailing addresses as required under subsection (a), so as to make such records undisclosable.

(e) ARRANGEMENTS WITH STATE AGENCIES AND AUTHORIZED PERSONS.—The Secretary, in carrying out the Secretary's duties and functions under this section, shall enter into arrangements—

(1) with State agencies to accept and to transmit to the Secretary requests for address information under this section and to accept and to transmit such information to authorized persons, and

(2) with State agencies and authorized persons otherwise to cooperate with the Secretary in carrying out the purposes of this section.

(f) PROCEDURES FOR ADMINISTRATIVE REVIEW.—The Secretary shall by regulation prescribe procedures which provide for administrative review of any determination that any authorized person has failed to meet the requirements of this section.

(g) UNAUTHORIZED DISCLOSURE OF INFORMATION.—Paragraphs (1), (2), and (3) of section 7213(a) of the Internal Revenue Code of 1986 shall apply with respect to the unauthorized willful disclosure to any person of address information or related blood donor records acquired or maintained by or under the Secretary, or pursuant to this section by any authorized person, or of information derived from any such address information or related blood donor records, in the same manner and to the same extent as such paragraphs apply with respect to unauthorized disclosures of return and return information described in such paragraphs. Paragraph (4) of section 7213(a) of such Code shall apply with respect to the willful offer of any item of material value in exchange for any such address information or related blood donor record in the same manner and to the same extent as such paragraph applies with respect to offers (in exchange for any return or return information) described in such paragraph.

(h) DEFINITIONS.—For purposes of this section—

(1) AUTHORIZED PERSON.—The term "authorized person" means—

(A) any agency of a State (or of a political subdivision of a State) which has duties or authority under State law relating to the public health or otherwise has the duty or authority under State law to regulate blood donations, and

(B) any entity engaged in the acceptance of blood donations which is licensed or registered by the Food and Drug Administration in connection with the acceptance of such blood donations, and which, in accordance with such regulations as may be prescribed by the Secretary, provides for—

(i) the confidentiality of any address information received pursuant to this section and related blood donor records,

(ii) blood donor notification procedures for individuals with respect to whom such information is requested and a finding has been made that they have or may have the virus for acquired immune deficiency syndrome, and

(iii) counseling services for such individuals who have been found to have such virus.

(2) RELATED BLOOD DONOR RECORD.—The term "related blood donor record" means any record, list, or compilation which indicates, directly or indirectly, the identity of any individual with respect to whom a request for address information has been made pursuant to this section.

(3) STATE.—The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Marianas, and the Trust Territory of the Pacific Islands.

RESEARCH ON OUTCOMES OF HEALTH CARE SERVICES AND PROCEDURES[109]

SEC. 1142. [42 U.S.C. 1320b-12] (a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—The Secretary, acting through the Administrator for Health Care Policy and Research, shall—

(A) conduct and support research with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically; and

(B) assure that the needs and priorities of the program under title XVIII are appropriately reflected in the development and periodic review and updating (through the process set forth in section 913 of the Public Health Service Act) of treatment-specific or condition-specific practice guidelines for clinical treatments and conditions in forms appropriate for use in clinical practice, for use in educational programs, and for use in reviewing quality and appropriateness of medical care.

(2) EVALUATIONS OF ALTERNATIVE SERVICES AND PROCEDURES.—In carrying out paragraph (1), the Secretary shall conduct or support evaluations of the comparative effects, on health and functional capacity, of alternative services and procedures utilized in preventing, diagnosing, treating, and clinically managing diseases, disorders, and other health conditions.

(3) INITIAL GUIDELINES.—

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[109] P.L. 101-239, §6103(b)(1), added this section, effective December 19, 1989.
See Vol. II, P.L. 101-239, §6103(b)(2), with respect to a report on linkage of public and private research related data.

(A) In carrying out paragraph (1)(B) of this subsection, and section 912(d) of the Public Health Service Act, the Secretary shall, by not later than January 1, 1991, assure the development of an initial set of the guidelines specified in paragraph (1)(B) that shall include not less than 3 clinical treatments or conditions that—

(i)(I) account for a significant portion of expenditures under title XVIII; and

(II) have a significant variation in the frequency or the type of treatment provided; or

(ii) otherwise meet the needs and priorities of the program under title XVIII, as set forth under subsection (b)(3).

(B)(i) The Secretary shall provide for the use of guidelines developed under subparagrah[110] (A) to improve the quality, effectiveness, and appropriateness of care provided under title XVIII. The Secretary shall determine the impact of such use on the quality, appropriateness, effectiveness, and cost of medical care provided under such title and shall report to the Congress on such determination by not later than January 1, 1993.

(ii) For the purpose of carrying out clause (i), the Secretary shall expend, from the amounts specified in clause (iii), $1,000,000 for fiscal year 1990 and $1,500,000 for each of the fiscal years 1991 and 1992.

(iii) For each fiscal year, for purposes of expenditures required in clause (ii)—

(I) 60 percent of an amount equal to the expenditure involved is appropriated from the Federal Hospital Insurance Trust Fund (established under section 1817); and

(II) 40 percent of an amount equal to the expenditure involved is appropriated from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841).

(b) PRIORITIES.—

(1) IN GENERAL.—The Secretary shall establish priorities with respect to the diseases, disorders, and other health conditions for which research and evaluations are to be conducted or supported under subsection (a). In establishing such priorities, the Secretary shall, with respect to a disease, disorder, or other health condition, consider the extent to which—

(A) improved methods of prevention, diagnosis, treatment, and clinical management can benefit a significant number of individuals;

(B) there is significant variation among physicians in the particular services and procedures utilized in making diagnoses and providing treatments or there is significant variation in the outcomes of health care services or procedures due to different patterns of diagnosis or treatment;

(C) the services and procedures utilized for diagnosis and treatment result in relatively substantial expenditures; and

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[110] As in original; should be "subparagraph".

(D) the data necessary for such evaluations are readily available or can readily be developed.

(2) PRELIMINARY ASSESSMENTS.—For the purpose of establishing priorities under paragraph (1), the Secretary may, with respect to services and procedures utilized in preventing, diagnosing, treating, and clinically managing diseases, disorders, and other health conditions, conduct or support assessments of the extent to which—

(A) rates of utilization vary among similar populations for particular diseases, disorders, and other health conditions;

(B) uncertainties exist on the effect of utilizing a particular service or procedure; or

(C) inappropriate services and procedures are provided.

(3) RELATIONSHIP WITH MEDICARE PROGRAM.—In establishing priorities under paragraph (1) for research and evaluation, and under section 914(a) of the Public Health Service Act for the agenda under such section, the Secretary shall assure that such priorities appropriately reflect the needs and priorities of the program under title XVIII, as set forth by the Administrator of the Health Care Financing Administration.

(c) METHODOLOGIES AND CRITERIA FOR EVALUATIONS.—For the purpose of facilitating research under subsection (a), the Secretary shall—

(1) conduct and support research with respect to the improvement of methodologies and criteria utilized in conducting research with respect to outcomes of health care services and procedures;

(2) conduct and support reviews and evaluations of existing research findings with respect to such treatment or conditions;

(3) conduct and support reviews and evaluations of the existing methodologies that use large data bases in conducting such research and shall develop new research methodologies, including data-based methods of advancing knowledge and methodologies that measure clinical and functional status of patients, with respect to such research;

(4) provide grants and contracts to research centers, and contracts to other entities, to conduct such research on such treatment or conditions, including research on the appropriate use of prescription drugs;

(5) conduct and support research and demonstrations on the use of claims data and data on clinical and functional status of patients in determining the outcomes, effectiveness, and appropriateness of such treatment; and

(6) conduct and support supplementation of existing data bases, including the collection of new information, to enhance data bases for research purposes, and the design and development of new data bases that would be used in outcomes and effectiveness research.

(d) STANDARDS FOR DATA BASES.—In carrying out this section, the Secretary shall develop—

(1) uniform definitions of data to be collected and used in describing a patient's clinical and functional status;

(2) common reporting formats and linkages for such data; and

(3) standards to assure the security, confidentiality, accuracy, and appropriate maintenance of such data.

(e) DISSEMINATION OF RESEARCH FINDINGS AND GUIDELINES.—

(1) IN GENERAL.—The Secretary shall provide for the dissemination of the findings of research and the guidelines described in subsection (a), and for the education of providers and others in the application of such research findings and guidelines.

(2) COOPERATIVE EDUCATIONAL ACTIVITIES.—In disseminating findings and guidelines under paragraph (1), and in providing for education under such paragraph, the Secretary shall work with professional associations, medical specialty and subspecialty organizations, and other relevant groups to identify and implement effective means to educate physicians, other providers, consumers, and others in using such findings and guidelines, including training for physician managers within provider organizations.

(f) EVALUATIONS.—The Secretary shall conduct and support evaluations of the activities carried out under this section to determine the extent to which such activities have had an effect on the practices of physicians in providing medical treatment, the delivery of health care, and the outcomes of health care services and procedures.

(g) RESEARCH WITH RESPECT TO DISSEMINATION.—The Secretary may conduct or support research with respect to improving methods of disseminating informaton on the effectiveness and appropriateness of health care services and procedures.

(h) REPORT TO CONGRESS.—Not later than February 1 of each of the years 1991 and 1992, and of each second year thereafter, the Secretary shall report to the Congress on the progress of the activities under this section during the preceding fiscal year (or preceding 2 fiscal years, as appropriate), including the impact of such activities on medical care (particularly medical care for individuals receiving benefits under title XVIII).

(i) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out this section—

(A) $50,000,000 for fiscal year 1990;
(B) $75,000,000 for fiscal year 1991;
(C) $110,000,000 for fiscal year 1992;
(D) $148,000,000 for fiscal year 1993; and
(E) $185,000,000 for fiscal year 1994.

(2) SPECIFICATIONS.—For the purpose of carrying out this section, for each of the fiscal years 1990 through 1992 an amount equal to two-thirds of the amounts authorized to be appropriated under paragraph (1), and for each of the fiscal years 1993 and 1994 an amount equal to 70 percent of such amounts, are to be appropriated in the following proportions from the following trust funds:

(A) 60 percent from the Federal Hospital Insurance Trust Fund (established under section 1817).

(B) 40 percent from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841).

(3) ALLOCATIONS.—

(A) For each fiscal year, of the amounts transferred or otherwise apropriated to carry out this section, the Secretary shall reserve appropriate amounts for each of the purposes specified in clauses (i) through (iv) of subparagraph (B).

(B) The purposes referred to in subparagraph (A) are—

(i) the development of guidelines, standards, performance measures, and review criteria;

(ii) research and evaluation;

(iii) data-base standards and development; and

(iv) education and information dissemination.

SOCIAL SECURITY ACCOUNT STATEMENTS[111]

Provision Upon Request

Sec. 1143[112]. [42 U.S.C. 1320b-13] (a)(1) Beginning not later than October 1, 1990, the Secretary shall provide upon the request of an eligible individual a social security account statement (hereinafter referred to as the "statement").

(2) Each statement shall contain—

(A) the amount of wages paid to and self-employment income derived by the eligible individual as shown by the records of the Secretary at the date of the request;

(B) an estimate of the aggregate of the employee and self-employment contributions of the eligible individual for old-age, survivors, and disability insurance as shown by the records of the Secretary on the date of the request;

(C) a separate estimate of the aggregate of the employee and self-employment contributions of the eligible individual for hospital insurance as shown by the records of the Secretary on the date of the request; and

(D) an estimate of the potential monthly retirement, disability, survivor, and auxiliary benefits payable on the eligible individual's account together with a description of the benefits payable under the medicare program of title XVIII.

(3) For purposes of this section, the term "eligible individual" means an individual who—

(A) has a social security account number,

(B) has attained age 25 or over, and

(C) has wages or net earnings from self-employment.

Notice to Eligible Individuals

(b) The Secretary shall, to the maximum extent practicable, take such steps as are necessary to assure that eligible individuals are informed of the availability of the statement described in subsection (a).

Mandatory Provision of Statements[113]

(c)(1) By not later than September 30, 1995, the Secretary shall provide a statement to each eligible individual who has attained age 60 by October 1, 1994, and who is not receiving benefits under title II and for whom a current mailing address can be determined through such methods as the Secretary determines to be appropriate. In fiscal years 1995 through 1999 the Secretary shall provide a statement to each eligible individual who attains age 60 in such fiscal years and who is not receiving benefits under title II and for whom a current mailing address can be determined through such methods as the Secretary determines to be appropriate. The Secretary shall provide with each statement to an eligible individual notice that such statement is updated annually and is available upon request.

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[111] P.L. 101-239, §10308, added this section, effective December 19, 1989.

[112] P.L. 101-508, §5111(a)(1), redesignated this §1142 as §1143.

[113] See Vol. II, P.L. 83-591, §6103(m)(7) [as added by P.L. 101-508, §5111(b)(1)], with respect to disclosure of address information by the Internal Revenue Service; §6103(p)(4) [as amended by P.L. 101-508, §5111(b)(2)], with respect to safeguards; §7213(a)(2) [as amended by P.L. 101-508, §5111(b)(3)], with respect to penalties for authorized disclosure.

(2) Beginning not later than October 1, 1999, the Secretary shall provide a statement on an annual[114] basis to each eligible individual who is not receiving benefits under title II and for whom a mailing address can be determined through such methods as the Secretary determines to be appropriate. With respect to statements provided to eligible individuals who have not attained age 50, such statements need not include estimates of monthly retirement benefits. However, if such statements provided to eligible individuals who have not attained age 50 do not include estimates of retirement benefit amounts, such statements shall include a description of the benefits (including auxiliary benefits) that are available upon retirement.

PART B—PEER REVIEW OF THE UTILIZATION AND QUALITY OF HEALTH CARE SERVICES[115]

PURPOSE

SEC. 1151. [42 U.S.C. 1320c] The purpose of this part is to establish the contracting process which the Secretary must follow pursuant to the requirements of section 1862(g) of this Act, including the definition of the utilization and quality control peer review organizations with which the Secretary shall contract, the functions such peer review organizations are to perform, the confidentiality of medical records, and related administrative matters to facilitate the carrying out of the purposes of this part.

DEFINITION OF UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATION

SEC. 1152. [42 U.S.C. 1320c-1] The term "utilization and quality control peer review organization" means an entity which—

(1)(A) is composed of a substantial number of the licensed doctors of medicine and osteopathy engaged in the practice of medicine or surgery in the area and who are representative of the practicing physicians in the area, designated by the Secretary under section 1153, with respect to which the entity shall perform services under this part, or (B) has available to it, by arrangement or otherwise, the services of a sufficient number of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area to assure that adequate peer review of the services provided by the various medical specialties and subspecialties can be assured;

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[114] P.L. 101-508, §5111(a)(2), struck out "a biennial" and substituted "an annual", effective November 5, 1990.

[115] As in original [P.L. 97-248, §143; 96 Stat. 382].

See Vol. II, P.L. 97-448, §309(d), with respect to evaluations of professional standards review organizations and selection of peer review organizations.

See Vol. II, P.L. 99-509, §9353(a)(4), with respect to small-area analysis.

See Vol. II, P.L. 100-203, §4091(a)(1), with respect to the one-time extensions to permit staggering of expiration dates; and §4094(e), with respect to the telecommunications demonstration projects.

See Vol. II, P.L. 101-508, §4205(c), with respect to coordination of PRO's and carriers.

(2) is able, in the judgment of the Secretary, to perform review functions required under section 1154 in a manner consistent with the efficient and effective administration of this part and to perform reviews of the pattern of quality of care in an area of medical practice where actual performance is measured against objective criteria which define acceptable and adequate practice; and

(3) has at least one individual who is a representative of consumers on its governing body.

CONTRACTS WITH UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATIONS

SEC. 1153. [42 U.S.C. 1320c-2] (a)(1) The Secretary shall establish throughout the United States geographic areas with respect to which contracts under this part will be made. In establishing such areas, the Secretary shall use the same areas as established under section 1152 of this Act as in effect immediately prior to the date of the enactment of the Peer Review Improvement Act of 1982[116], but subject to the provisions of paragraph (2).

(2) As soon as practicable after the date of the enactment of the Peer Review Improvement Act of 1982, the Secretary shall consolidate such geographic areas, taking into account the following criteria:

(A) Each State shall generally be designated as a geographic area for purposes of paragraph (1).

(B) The Secretary shall establish local or regional areas rather than State areas only where the volume of review activity or other relevant factors (as determined by the Secretary) warrant such an establishment, and the Secretary determines that review activity can be carried out with equal or greater efficiency by establishing such local or regional areas. In applying this subparagraph the Secretary shall take into account the number of hospital admissions within each State for which payment may be made under title XVIII or a State plan approved under title XIX, with any State having fewer than 180,000 such admissions annually being established as a single statewide area, and no local or regional area being established which has fewer than 60,000 total hospital admissions (including public and private pay patients) under review annually, unless the Secretary determines that other relevant factors warrant otherwise.

(C) No local or regional area shall be designated which is not a self-contained medical service area, having a full spectrum of services, including medical specialists' services.

(b)(1) The Secretary shall enter into a contract with a utilization and quality control peer review organization for each area established under subsection (a) if a qualified organization is available in such area and such organization and the Secretary have negotiated a proposed contract which the Secretary determines will be carried out by such organization in a manner consistent with the efficient and effective administration of this part. If more than one such qualified organization meets the requirements of the preceding sentence, priority shall be given to any such organization which is described in section 1152(1)(A).

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[116] P.L. 97-248, Title I, subtitle C, September 3, 1982; 96 Stat. 381.

(2)(A) Prior to November 15, 1984, the Secretary shall not enter into a contract under this part with any entity which is, or is affiliated with (through management, ownership, or common control), an entity (other than a self-insured employer) which directly or indirectly makes payments to any practitioner or provider whose health care services are reviewed by such entity or would be reviewed by such entity if it entered into a contract with the Secretary under this part. For purposes of this paragraph, an entity shall not be considered to be affiliated with another entity which makes payments (directly or indirectly) to any practitioner or provider, by reason of management, ownership, or common control, if the management, ownership, or common control consists only of members of the governing board being affiliated (through management, ownership, or common control) with a health maintenance organization or competitive medical plan which is an "eligible organization" as defined in section 1876(b).

(B) If, after November 14, 1984, the Secretary determines that there is no other entity available for an area with which the Secretary can enter into a contract under this part, the Secretary may then enter into a contract under this part with an entity described in subparagraph (A) for such area if such entity otherwise meets the requirements of this part.

(3)(A) The Secretary shall not enter into a contract under this part with any entity which is, or is affiliated with (through management, ownership, or common control), a health care facility, or association of such facilities, within the area served by such entity or which would be served by such entity if it entered into a contract with the Secretary under this part.

(B) For purposes of subparagraph (A), an entity shall not be considered to be affiliated with a health care facility or association of facilities by reason of management, ownership. or common control if the management, ownership, or common control consists only of not more than 20 percent of the members of the governing board of the entity being affiliated (through management, ownership, or common control) with one or more of such facilities or associations.

(c) Each contract with an organization under this section shall provide that—

(1) the organization shall perform the functions set forth in section 1154(a), or may subcontract for the performance of all or some of such functions (and for purposes of paragraphs (2) and (3) of subsection (b), a subcontract under this paragraph shall not constitute an affiliation with the subcontractor);

(2) the Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the contract;

(3) the contract shall be for an initial term of three years and shall be renewable on a triennial basis thereafter;

(4) if the Secretary intends not to renew a contract, he shall notify the organization of his decision at least 90 days prior to the expiration of the contract term, and shall provide the organization an opportunity to present data, interpretations of

data, and other information pertinent to its performance under the contract, which shall be reviewed in a timely manner by the Secretary;

(5) the organization may terminate the contract upon 90 days notice to the Secretary;

(6) the Secretary may terminate the contract prior to the expiration of the contract term upon 90 days notice to the organization if the Secretary determines that—

(A) the organization does not substantially meet the requirements of section 1152; or

(B) the organization has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part, but only after such organization has had an opportunity to submit data and have such data reviewed by the panel established under subsection (d);

(7) the Secretary shall include in the contract negotiated objectives against which the organization's performance will be judged, and negotiated specifications for use of regional norms, or modifications thereof based on national norms, for performing review functions under the contract; and

(8) reimbursement shall be made to the organization on a monthly basis, with payments for any month being made not later than 15 days after the close of such month.

In evaluating the performance of utilization and quality control peer review organizations under contracts under this part, the Secretary shall place emphasis on the performance of such organizations in educating providers and practitioners (particularly those in rural areas) concerning the review process and criteria being applied by the organization.

(d)(1) Prior to making any termination under subsection (c)(6)(B), the Secretary must provide the organization with an opportunity to provide data, interpretations of data, and other information pertinent to its performance under the contract. Such data and other information shall be reviewed in a timely manner by a panel appointed by the Secretary, and the panel shall submit a report of its findings to the Secretary in a timely manner. The Secretary shall make a copy of the report available to the organization.

(2) The Secretary may accept or not accept the findings of the panel. After the panel has submitted a report with respect to an organization, the Secretary may, with the concurrence of the organization, amend the contract to modify the scope of the functions to be carried out by the organization, or in any other manner. The Secretary may terminate a contract under the authority of subsection (c)(6)(B) upon 90 days notice after the panel has submitted a report, or earlier if the organization so agrees.

(3) A panel appointed by the Secretary under this subsection shall consist of not more than five individuals, each of whom shall be a member of a utilization and quality control peer review organization having a contract with the Secretary under this part. While serving on such panel individuals shall be paid at a per diem rate not to exceed the current per diem equivalent at the time that service on the panel is rendered for grade GS-18 under section 5332 of title 5, United States Code. Appointments shall be made without regard to title 5, United States Code.

(4) During the period after the Secretary has given notice of intent to terminate a contract, and prior to the time that the Secretary enters into a contract with another utilization and quality control peer review organization, the Secretary may transfer review responsibilities of the organization under the contract being terminated to another utilization and quality control peer review organization, or to an intermediary or carrier having an agreement under section 1816 or a contract under section 1842.

(e)(1) Except as provided in paragraph (2), contracting authority of the Secretary under this section may be carried out without regard to any provision of law relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the purposes of this part. The Secretary may use different contracting methods with respect to different geographical areas.

(2) If a peer review organization with a contract under this section is required to carry out a review function in addition to any function required to be carried out at the time the Secretary entered into or renewed the contract with the organization, the Secretary shall, before requiring such organization to carry out such additional function, negotiate the necessary contractual modifications, including modifications that provide for an appropriate adjustment (in light of the cost of such additional function) to the amount of reimbursement made to the organization.

(f) Any determination by the Secretary to terminate or not to renew a contract under this section shall not be subject to judicial review.

(g) The Secretary shall provide that fiscal intermediaries furnish to peer review organizations, each month on a timely basis, data necessary to initiate the review process under section 1154(a) on a timely basis. If the Secretary determines that a fiscal intermediary is unable to furnish such data on a timely basis, the Secretary shall require the hospital to do so.

(h)(1) The Secretary shall publish in the Federal Register any new policy or procedure adopted by the Secretary that affects substantially the performance of contract obligations under this section not less than 30 days before the date on which such policy or procedure is to take effect. This paragraph shall not apply to the extent it is inconsistent with a statutory deadline.

(2) The Secretary shall publish in the Federal Register the general criteria and standards used for evaluating the efficient and effective performance of contract obligations under this section and shall provide opportunity for public comment with respect to such criteria and standards.

(3) The Secretary shall regularly furnish each peer review organization with a contract under this section with a report that documents the performance of the organization in relation to the performance of other such organizations.

(i)(1) Notwithstanding any other provision of this section, the Secretary shall not renew a contract with any organization that is not an in-State organization (as defined in paragraph (3)) unless the Secretary has first complied with the requirements of paragraph (2).

(2)(A) Not later than six months before the date on which a contract period ends with respect to an organization that is not an in-

State organization, the Secretary shall publish in the Federal Register—

(i) the date on which such period ends; and

(ii) the period of time in which an in-State organization may submit a proposal for the contract ending on such date.

(B) If one or more qualified in-State organizations submits a proposal within the period of time specified under subparagraph (A)(ii), the Secretary shall not automatically renew the current contract on a noncompetitive basis, but shall provide for competition for the contract in the same manner as a new contract under subsection (b).

(3) For purposes of this subsection, an in-State organization is an organization that has its primary place of business in the State in which review will be conducted (or, which is owned by a parent corporation the headquarters of which is located in such State).

FUNCTIONS OF PEER REVIEW ORGANIZATIONS[117]

SEC. 1154. [42 U.S.C. 1320c-3] (a) Any utilization and quality control peer review organization entering into a contract with the Secretary under this part must perform the following functions:

(1) The organization shall review some or all of the professional activities in the area, subject to the terms of the contract and subject to the requirements of subsection (d), of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services and items for which payment may be made (in whole or in part) under title XVIII (including where payment is made for such services to eligible organizations pursuant to contracts under section 1876) for the purpose of determining whether—

(A) such services and items are or were reasonable and medically necessary and whether such services and items are not allowable under subsection (a)(1) or (a)(9) of section 1862;

(B) the quality of such services meets professionally recognized standards of health care; and

(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient health care facility of a different type. If the organization performs such reviews with respect to a type of health care practitioner other than medical doctors, the organization shall establish procedures for the involvement of health care practitioners of that type in such reviews.[118]

(2) The organization shall determine, on the basis of the review carried out under subparagraphs (A), (B), and (C) of paragraph (1), whether payment shall be made for services under title XVIII. Such determination shall constitute the conclusive determination on those issues for purposes of payment under title XVIII, except that payment may be made if—

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[117] See Vol. II, P.L. 100-203, §4005(b)(3), with respect to the Secretary's report to Congress.

[118] P.L. 101-239, §6224(a)(1), added this sentence, applicable to contracts entered into after December 19, 1989.

(A) such payment is allowed by reason of section 1879;

(B) in the case of inpatient hospital services or extended care services, the peer review organization determines that additional time is required in order to arrange for postdischarge care, but payment may be continued under this subparagraph for not more than two days, but only in the case where the provider of such services did not know and could not reasonably have been expected to know (as determined under section 1879) that payment would not otherwise be made for such services under title XVIII prior to notification by the organization under paragraph (3);

(C) such determination is changed as the result of any hearing or review of the determination under section 1155; or

(D) such payment is authorized under section 1861(v)(1)(G).

The organization shall identify cases for which payment should not be made by reason of paragraph (1)(B) only through the use of criteria developed pursuant to guidelines established by the Secretary.[119]

(3)(A) Subject to subparagraphs (B) and (D)[120], whenever the organization makes a determination that any health care services or items furnished or to be furnished to a patient by any practitioner or provider are disapproved, the organization shall promptly notify such patient and the agency or organization responsible for the payment of claims under title XVIII of this Act of such determination.

(B) The notification under subparagraph (A) with respect to services or items disapproved by reason of subparagraph (A) or (C) of paragraph (1)[121] shall not occur until 20 days after the date that the organization has—

(i) made a preliminary notification to such practitioner or provider of such proposed determination, and

(ii) provided such practitioner or provider an opportunity for discussion and review of the proposed determination.

(C) The discussion and review conducted under subparagraph (B)(ii) shall not affect the rights of a practitioner or provider to a formal reconsideration of a determination under this part (as provided under section 1155).

(D) The notification under subparagraph (A) with respect to services or items disapproved by reason of paragraph (1)(B) shall not occur until after—

(i) the organization has notified the practitioner or provider involved of the determination and of the practitioner's or provider's right to a formal reconsideration of the determination under section 1155, and

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[119] P.L. 101-508, §4205(g)(2)(A), struck out "Determinations that payment should not be made by reason of subparagraph (B) of paragraph (1) shall be made only on the basis of criteria which are consistent with guidelines established by the Secretary." and substituted this sentence, effective as if included in the enactment of P.L. 99-272.

[120] P.L. 101-239, §6224(b)(1)(A), struck out "subparagraph (B)" and substituted "subparagraphs (B) and (D)", applicable to determinations by utilization and quality control peer review organizations with respect to which preliminary notifications were made under §1154(a)(3)(B) on or after January 19, 1990.

[121] P.L. 101-239, §6224(b)(1)(B), inserted "with respect to services or items disapproved by reason of subparagraph (A) or (C) of paragraph (1)", applicable to determinations by utilization and quality control peer review organizations with respect to which preliminary notifications were made under §1154(a)(3)(B) on or after January 19, 1990.

(ii) if the provider or practitioner requests such a reconsideration, the organization has made such a reconsideration.

If a provider or practitioner is provided a reconsideration, such reconsideration shall be in lieu of any subsequent reconsideration to which the provider or practitioner may be otherwise entitled under section 1155, but shall not affect the right of a beneficiary from seeking reconsideration under such section of the organization's determination (after any reconsideration requested by the provider or physician under clause (ii)).[122]

(E)(i)[123] In the case of services and items provided by a physician that were[124] disapproved by reason of paragraph (1)(B), the notice to the patient shall state the following: "In the judgment of the peer review organization, the medical care received was not acceptable under the medicare program. The reasons for the denial have been discussed with your physician[125].".

(ii) In the case of services or items provided by an entity or practitioner other than a physician, the Secretary may substitute the entity or practitioner which provided the services or items for the term "physician" in the notice described in clause (i).[126]

(4)(A) The organization shall, after consultation with the Secretary, determine the types and kinds of cases (whether by type of health care or diagnosis involved, or whether in terms of other relevant criteria relating to the provision of health care services) with respect to which such organization will, in order to most effectively carry out the purposes of this part, exercise review authority under the contract. The organization shall notify the Secretary periodically with respect to such determinations. Each peer review organization shall provide that a reasonable proportion of its activities are involved with reviewing, under paragraph (1)(B), the quality of services and that a reasonable allocation of such activities is made among the different cases and settings (including post-acute-care settings, ambulatory settings, and health maintenance organizations). In establishing such allocation, the organization shall consider (i) whether there is reason to believe that there is a particular need for reviews of particular cases or settings because of previous problems regarding quality of care, (ii) the cost of such reviews and the likely yield of such reviews in terms of number and seriousness of quality of care problems likely to be discovered as a result of such reviews, and (iii) the availability and adequacy of alternative quality review and assurance mechanisms.

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[122] P.L. 101-239, §6224(b)(1)(C), added this subparagraph, applicable to determinations by utilization and quality control peer review organizations with respect to which preliminary notifications were made under §1154(a)(3)(B) on or after January 19, 1990.

[123] P.L. 101-508, §4205(g)(1)(A)(i), redesignated subparagraph (E) as clause (i).

[124] P.L. 101-508, §4205(g)(1)(A)(ii), inserted "provided by a physician that were", effective as if included in the enactment of P.L. 101-239.

[125] P.L. 101-508, §4205(g)(1)(A)(iii), struck out "and hospital", effective as if included in the enactment of P.L. 101-239.

[126] P.L. 101-508, §4205(g)(1)(A)(iv), added clause (ii), effective as if included in the enactment of P.L. 101-239.

P.L. 101-239, §6224(b)(1)(C), added this subparagraph, applicable to determinations by utilization and quality control peer review organizations with respect to which preliminary notifications were made under §1154(a)(3)(B) on or after January 19, 1990.

(B) The contract of each organization shall provide for the review of services (including both inpatient and outpatient services) provided by eligible organizations pursuant to a risk-sharing contract under section 1876 (or subject to review under section 1882(t))[127] for the purpose of determining whether the quality of such services meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings and whether individuals enrolled with an eligible organization have adequate access to health care services provided by or through such organization (as determined, in part, by a survey of individuals enrolled with the organization who have not yet used the organization to receive such services). The contract of each organization shall also provide that with respect to health care provided by a health maintenance organization or competitive medical plan under section 1876, the organization shall maintain a beneficiary outreach program designed to apprise individuals receiving care under such section of the role of the peer review system, of the rights of the individual under such system, and of the method and purposes for contacting the organization. The previous two sentences shall not apply with respect to a contract year if another entity has been awarded a contract under subparagraph (C). Under the contract the level of effort expended by the organization on reviews under this subparagraph shall be equivalent, on a per enrollee basis, to the level of effort expended by the organization on utilization and quality reviews performed with respect to individuals not enrolled with an eligible organization.

(C) The Secretary may provide, by contract under competitive procurement procedures on a State-by-State basis in up to 25 States, for the review described in subparagraph (B) by an appropriate entity (which may be a peer review organization described in that subparagraph). In selecting among States in which to conduct such competitive procurement procedures, the Secretary may not select States which, as a group, have more than 50 percent of the total number of individuals enrolled with eligible organizations under section 1876. Under a contract with an entity under this subparagraph—

(i) the entity must be, or must meet all the requirements under section 1152 to be, a utilization and quality control peer review organization (other than the ability to perform review functions under this section that are not described in subparagraph (B)),

(ii) the contract must meet the requirement of section 1153(b)(3), and

(iii) the level of effort expended under the contract shall be, to the extent practicable, not less than the level of effort that would otherwise be required under the third sentence of subparagraph (B) if this subparagraph did not apply.

(5) The organization shall consult with nurses and other professional health care practitioners (other than physicians

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[127] P.L. 101-508, §4358(b)(3), inserted "(or subject to review under section 1882(t))", applicable only in 15 States (as determined by the Secretary) and only during the 3-year period beginning with 1992.

described in section 1861(r)(1)) and with representatives of institutional and noninstitutional providers of health care services, with respect to the organization's responsibility for the review under paragraph (1) of the professional activities of such practitioners and providers.

(6)(A) The organization shall, consistent with the provisions of its contract under this part, apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice within the geographic area served by the organization as principal points of evaluation and review, taking into consideration national norms where appropriate. Such norms with respect to treatment for particular illnesses or health conditions shall include—

(i) the types and extent of the health care services which, taking into account differing, but acceptable, modes of treatment and methods of organizing and delivering care, are considered within the range of appropriate diagnosis and treatment of such illness or health condition, consistent with professionally recognized and accepted patterns of care; and

(ii) the type of health care facility which is considered, consistent with such standards, to be the type in which health care services which are medically appropriate for such illness or condition can most economically be provided.

As a component of the norms described in clause (i) or (ii), the organization shall take into account the special problems associated with delivering care in remote rural areas, the availability of service alternatives to inpatient hospitalization, and other appropriate factors (such as the distance from a patient's residence to the site of care, family support, availability of proximate alternative sites of care, and the patient's ability to carry out necessary or prescribed self-care regimens) that could adversely affect the safety or effectiveness of treatment provided on an outpatient basis.

(B) The organization shall—

(i) offer to provide, several times each year, for a physician representing the organization to meet (at a hospital or at a regional meeting) with medical and administrative staff of each hospital (the services of which are reviewed by the organization) respecting the organization's review of the hospital's services for which payment may be made under title XVIII, and

(ii) publish (not less often than annually) and distribute to providers and practitioners whose services are subject to review a report that describes the organization's findings with respect to the types of cases in which the organization has frequently determined that (I) inappropriate or unnecessary care has been provided, (II) services were rendered in an inappropriate setting, or (III) services did not meet professionally recognized standards of health care.

(7) The organization, to the extent necessary and appropriate to the performance of the contract, shall—

(A)(i) make arrangements to utilize the services of persons who are practitioners of, or specialists in, the various areas of medicine (including dentistry, optometry, and podiatry[128]), or other types of health care, which persons shall, to the maximum extent practicable, be individuals engaged in the practice of their profession within the area served by such organization; and

(ii) in the case of psychiatric and physical rehabilitation services, make arrangements to ensure that (to the extent possible) initial review of such services be made by a physician who is trained in psychiatry or physical rehabilitation (as appropriate).[129]

(B) undertake such professional inquiries either before or after, or both before and after, the provision of services with respect to which such organization has a responsibility for review which in the judgment of such organization will facilitate its activities;

(C) examine the pertinent records of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under paragraph (1); and

(D) inspect the facilities in which care is rendered or services are provided (which are located in such area) of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under paragraph (1).

(8) The organization shall perform such duties and functions and assume such responsibilities and comply with such other requirements as may be required by this part or under regulations of the Secretary promulgated to carry out the provisions of this part or as may be required to carry out section 1862(a)(15).

(9)(A)[130] The organization shall collect such information relevant to its functions, and keep and maintain such records, in such form as the Secretary may require to carry out the purposes of this part, and shall permit access to and use of any such information and records as the Secretary may require for such purposes, subject to the provisions of section 1160.

(B) If the organization finds, after notice and hearing, that a physician has furnished services in violation of this subsection, the organization shall notify the State board or boards responsible for the licensing or disciplining of the physician of its finding and decision.[131]

(10) The organization shall coordinate activities, including information exchanges, which are consistent with economical and efficient operation of programs among appropriate public and private agencies or organizations including—

(A) agencies under contract pursuant to sections 1816 and 1842 of this Act;

(B) other peer review organizations having contracts under this part; and

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[128] P.L. 101-508, §4205(b)(1)(A), inserted ", optometry, and podiatry", applicable to contracts entered into or renewed on or after November 5, 1990.

[129] Punctuation as in original.

[130] P.L. 101-508, §4205(d)(1)(A)(i), redesignated paragraph (9) as subparagraph (A).

[131] P.L. 101-508, §4205(d)(1)(A)(ii), added subparagraph (B), applicable to notices of proposed sanctions issued more than 60 days after November 5, 1990.

(C) other public or private review organizations as may be appropriate.

(11) The organization shall make available its facilities and resources for contracting with private and public entities paying for health care in its area for review, as feasible and appropriate, of services reimbursed by such entities.

(12) The organization shall perform the review, referral, and other functions required under section 1164.

(13) Notwithstanding paragraph (4), the organization shall perform the review described in paragraph (1) with respect to early readmission cases to determine if the previous inpatient hospital services and the post-hospital services met professionally recognized standards of health care. Such reviews may be performed on a sample basis if the organization and the Secretary determine it to be appropriate. In this paragraph, an "early readmission case" is a case in which an individual, after discharge from a hospital, is readmitted to a hospital less than 31 days after the date of the most recent previous discharge.

(14) The organization shall conduct an appropriate review of all written complaints about the quality of services (for which payment may otherwise be made under title XVIII) not meeting professionally recognized standards of health care, if the complaint is filed with the organization by an individual entitled to benefits for such services under such title (or a person acting on the individual's behalf). The organization shall inform the individual (or representative) of the organization's final disposition of the complaint. Before the organization concludes that the quality of services does not meet professionally recognized standards of health care, the organization must provide the practitioner or person concerned with reasonable notice and opportunity for discussion.

(15) During each year of the contract entered into under section 1153(b), the organization shall perform significant on-site review activities, including on-site review in at least 20 percent of the rural hospitals in the organization's area.

(16) The organization shall provide for a review and report to the Secretary when requested by the Secretary under section 1867(d)(3). The organization shall provide reasonable notice of the review to the physician and hospital involved. Within the time period permitted by the Secretary, the organization shall provide a reasonable opportunity for discussion with the physician and hospital involved, and an opportunity for the physician and hospital to submit additional information, before issuing its report to the Secretary under such section.[132]

(b)(1) No physician shall be permitted to review—

(A) health care services provided to a patient if he was directly responsible for providing such services; or

(B) health care services provided in or by an institution, organization, or agency, if he or any member of his family has, directly or indirectly, a significant financial interest in such institution, organization, or agency.

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[132] P.L. 100-360, §203(d)(2), added paragraph (16), applicable to items and services furnished on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed paragraph (16), effective January 1, 1990. [For paragraph (16) as it formerly read, see Vol. III, P.L. 101-234.]

P.L. 101-508, §4027(sic)(a)(1)(B), added this paragraph (16), applicable to contracts under part B of title XI as of February 1, 1991, and applicable to actions occurring on or after May 1, 1991.

(2) For purposes of this subsection, a physician's family includes only his spouse (other than a spouse who is legally separated from him under a decree of divorce or separate maintenance), children (including legally adopted children), grandchildren, parents, and grandparents.

(c) No utilization and quality control peer review organization shall utilize the services of any individual who is not a duly licensed doctor of medicine, osteopathy, dentistry, optometry, or podiatry[133] to make final determinations of denial decisions in accordance with its duties and functions under this part with respect to the professional conduct of any other duly licensed doctor of medicine, osteopathy, dentistry, optometry, or podiatry[134], or any act performed by any duly licensed doctor of medicine, osteopathy, dentistry, optometry, or podiatry[135] in the exercise of his profession.

(d) Each contract under this part shall require that the utilization and quality control peer review organization's review responsibility pursuant to subsection (a)(1) will include review of all ambulatory surgical procedures specified pursuant to section 1833(i)(1)(A) which are performed in the area, or, at the discretion of the Secretary (and except as provided in section 1164) a sample of such procedures.

(e)(1) If—

(A) a hospital has determined that a patient no longer requires inpatient hospital care, and

(B) the attending physician has agreed with the hospital's determination,

the hospital may provide the patient (or the patient's representative) with a notice (meeting conditions prescribed by the Secretary under section 1879) of the determination.

(2) If—

(A) a hospital has determined that a patient no longer requires inpatient hospital care, but

(B) the attending physician has not agreed with the hospital's determination,

the hospital may request the appropriate peer review organization to review under subsection (a) the validity of the hospital's determination. If the hospital requests such a review, it shall also notify the patient that the review has been requested.

(3)(A) If a patient (or a patient's representative)—

(i) has received a notice under paragraph (1), and

(ii) requests the appropriate peer review organization to review the determination,

then, the organization shall conduct a review under subsection (a) of the validity of the hospital's determination and shall provide notice (by telephone and in writing) to the patient or representative and the hospital and attending physician involved of the results of the review. Such review shall be conducted regardless of whether or not the hospital will charge for continued hospital care or whether or not the patient will be liable for payment for such continued care.

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[133] P.L. 101-508, §4205(b)(1)(B), struck out "or dentistry" and substituted "dentistry, optometry, or podiatry", applicable to contracts entered into or renewed on or after November 5, 1990.

[134] P.L. 101-508, §4205(b)(1)(B), struck out "or dentistry" and substituted "dentistry, optometry, or podiatry", applicable to contracts entered into or renewed on or after November 5, 1990.

[135] P.L. 101-508, §4205(b)(1)(B), struck out "or dentistry" and substituted "dentistry, optometry, or podiatry", applicable to contracts entered into or renewed on or after November 5, 1990.

(B) If a patient (or a patient's representative) requests a review under subparagraph (A) while the patient is still an inpatient in the hospital and not later than noon of the first working day after the date the patient receives the notice under paragraph (1), then—

(i) the hospital shall provide to the appropriate peer review organization the records required to review the determination by the close of business of such first working day, and

(ii) the peer review organization must provide the notice under subparagraph (A) by not later than one full working day after the date the organization has received the request and such records.

(4) If—

(A) a request is made under paragraph (3)(A) not later than noon of the first working day after the date the patient (or patient's representative) receives the notice under paragraph (1), and

(B) the conditions described in section 1879(a)(2) with respect to the patient or representative are met,

the hospital may not charge the patient for inpatient hospital services furnished before noon of the day after the date the patient or representative receives notice of the peer review organization's decision.

(5) In any review conducted under paragraph (2) or (3), the organization shall solicit the views of the patient involved (or the patient's representative).

(f) The Secretary, in consultation with appropriate experts, shall identify methods that would be available to assist peer review organizations (under subsection (a)(4)) in identifying those cases which are more likely than others to be associated with a quality of services which does not meet professionally recognized standards of health care.

RIGHT TO HEARING AND JUDICIAL REVIEW

SEC. 1155. [42 U.S.C. 1320c-4] Any beneficiary who is entitled to benefits under title XVIII, and, subject to section 1154(a)(3)(D),[136] any practitioner or provider, who is dissatisfied with a determination made by a contracting peer review organization in conducting its review responsibilities under this part, shall be entitled to a reconsideration of such determination by the reviewing organization. Where the reconsideration is adverse to the beneficiary and where the matter in controversy is $200 or more, such beneficiary shall be entitled to a hearing by the Secretary (to the same extent as is provided in section 205(b)), and, where the amount in controversy is $2,000 or more, to judicial review of the Secretary's final decision.

OBLIGATIONS OF HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES; SANCTIONS AND PENALTIES; HEARINGS AND REVIEW[137]

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[136] P.L. 101-239, §6224(b)(2), inserted ", subject to section 1154(a)(3)(D),", applicable to determinations by utilization and quality control peer review orgnizations with respect to which preliminary notifications were made under §1154(a)(3)(B) on or after January 19, 1990.

[137] See Vol. II, P.L. 100-203, §4095(e), with respect to a report on improvements in procedures for imposing sanctions.

SEC. 1156. [42 U.S.C. 1320c-5] (a) It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act—

(1) will be provided economically and only when, and to the extent, medically necessary;

(2) will be of a quality which meets professionally recognized standards of health care; and

(3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

(b)(1) If after reasonable notice and opportunity for discussion with the practitioner or person concerned, and, if appropriate, after the practitioner or person has been given a reasonable opportunity to enter into and complete a corrective action plan (which may include remedial education) agreed to by the organization, and has failed successfully to complete such plan,[138] any organization having a contract with the Secretary under this part determines that such practitioner or person has—

(A) failed in a substantial number of cases substantially to comply with any obligation imposed on him under subsection (a), or

(B) grossly and flagrantly violated any such obligation in one or more instances,

such organization shall submit a report and recommendations to the Secretary. If the Secretary agrees with such determination, and determines that such practitioner or person, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under this Act, has demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, the Secretary (in addition to any other sanction provided under law) may exclude (permanently or for such period as the Secretary may prescribe) such practitioner or person from eligibility to provide services under this Act on a reimbursable basis. In determining whehter[139] a practitioner or person has demonstrated an unwillingness or lack of ability substantially to comply with such obligations, the Secretary shall consider the practitioner's or person's willingness or lack of ability, during the period before the organization submits its report and recommendations, to enter into and successfully complete a corrective action plan.[140] If the Secretary fails to act upon the recommendations submitted to him by such organization within 120 days after such submission, such practitioner or person shall be excluded from eligibility to provide services on a reimbursable basis until such time as the Secretary determines otherwise.

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[138] P.L. 101-508, §4205(a)(1)(A), inserted "and, if appropriate, after the practitioner or person has been given a reasonable opportunity to enter into and complete a corrective action plan (which may include remedial education) agreed to by the organization, and has failed successfully to complete such plan,", applicable to initial determinations made by organizations on or after November 5, 1990.

[139] As in original. Probably should be "whether".

[140] P.L. 101-508, §4205(a)(1)(B), added this sentence, applicable to initial determinations made by organizations on or after November 5, 1990.

(2) A determination made by the Secretary under this subsection to exclude a practitioner or person shall be effective on the same date and in the same manner as an exclusion from participation under the programs under this Act becomes effective under section 1128(c), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(3) In lieu of the sanction authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or person to provide such health care services on a reimbursable basis) such practitioner or person pays to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or person of health care services which were medically improper or unnecessary, an amount not in excess of the actual or estimated cost of the medically improper or unnecessary services so provided. Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the practitioner or person from whom such amount is claimed.

(4) Any practitioner or person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(5) Before the Secretary may effect an exclusion under paragraph (2) in the case of a provider or practitioner located in a rural health professional shortage area[141] or in a county with a population of less than 70,000, the provider or practitioner adversely affected by the determination is entitled to a hearing before an administrative law judge (described in section 205(b)) respecting whether the provider or practitioner should be able to continue furnishing services to individuals entitled to benefits under this Act, pending completion of the administrative review procedure under paragraph (4). If the judge does not determine, by a preponderance of the evidence, that the provider or practitioner will pose a serious risk to such individuals if permitted to continue furnishing such services, the Secretary shall not effect the exclusion under paragraph (2) until the provider or practitioner has been provided reasonable notice and opportunity for an administrative hearing thereon under paragraph (4).[142]

(6) When the Secretary effects an exclusion of a physician under paragraph (2), the Secretary shall notify the State board responsible for the licensing of the physician of the exclusion.[143]

(c) It shall be the duty of each utilization and quality control peer review organization to use such authority or influence it may possess as a professional organization, and to enlist the support of any other professional or governmental organization having influence or authority over health care practitioners and any other person (including a hospital or other health care facility, organization, or agency) providing health care services in the area served by such review organization, in assuring that each practitioner or person (referred to in subsection (a)) providing health care services in such area shall comply with all obligations imposed on him under subsection (a).

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[141] P.L. 101-597, §401(c)(1), struck out "health manpower shortage area (HMSA)" and substituted "health professional shortage area", effective November 16, 1990.

[142] See Vol. II, P.L. 100-203, §4095(c), with respect to the transition for current cases; and subsection (d), with respect to redeterminations in certain cases.

[143] P.L. 101-508, §4205(d)(2)(A), added paragraph (6), applicable to sanctions effected more than 60 days after November 5, 1990.

LIMITATION ON LIABILITY

SEC. 1157. [42 U.S.C. 1320c-6] (a) Notwithstanding any other provision of law, no person providing information to any organization having a contract with the Secretary under this part shall be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) unless—

(1) such information is unrelated to the performance of the contract of such organization; or

(2) such information is false and the person providing it knew, or had reason to believe, that such information was false.

(b) No organization having a contract with the Secretary under this part and no[144] person who is employed by, or who has a fiduciary relationship with, any such organization or who furnishes professional services to such organization, shall be held by reason of the performance[145] of any duty, function, or activity required or authorized pursuant to this part or to a valid contract entered into under this part, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided due care was exercised in the performance of such duty, function, or activity[146].

(c) No doctor of medicine or osteopathy and no provider (including directors, trustees, employees, or officials thereof) of health care services shall be civilly liable to any person under any law of the United States or of any State (or political subdivision thereof) on account of any action taken by him in compliance with or reliance upon professionally developed norms of care and treatment applied by an organization under contract pursuant to section 1153 operating in the area where such doctor of medicine or osteopathy or provider took such action; but only if—

(1) he takes such action in the exercise of his profession as a doctor of medicine or osteopathy or in the exercise of his functions as a provider of health care services; and

(2) he exercised due care in all professional conduct taken or directed by him and reasonably related to, and resulting from, the actions taken in compliance with or reliance upon such professionally accepted norms of care and treatment.

(d) The Secretary shall make payment to an organization under contract with him pursuant to this part, or to any member or employee thereof, or to any person who furnishes legal counsel or services to such organization, in an amount equal to the reasonable amount of the expenses incurred, as determined by the Secretary, in connection with the defense of any suit, action, or proceeding brought against such organization, member, or employee related to the performance of any duty or function under such contract by such organization, member, or employee.

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[144] P.L. 101-508, §4205(f)(1), inserted "organization having a contract with the Secretary under this part and no", effective November 5, 1990.

[145] P.L. 101-508, §4205(f)(2), struck out "by him", effective November 5, 1990.

[146] P.L. 101-508, §4205(f)(3), struck out "he has exercised due care" and substituted "due care was exercised in the performance of such duty, function, or activity", effective November 5, 1990.

APPLICATION OF THIS PART TO CERTAIN STATE PROGRAMS RECEIVING FEDERAL FINANCIAL ASSISTANCE

SEC. 1158. [42 U.S.C. 1320c-7] (a) A State plan approved under title XIX of this Act may provide that the functions specified in section 1154 may be performed in an area by contract with a utilization and quality control peer review organization that has entered into a contract with the Secretary in accordance with the provisions of section 1862(g).

(b) In the event a State enters into a contract in accordance with subsection (a), the Federal share of the expenditures made to the contracting organization for its costs in the performance of its functions under the State plan shall be 75 percent (as provided in section 1903(a)(3)(C)).

AUTHORIZATION FOR USE OF CERTAIN FUNDS TO ADMINISTER THE PROVISIONS OF THIS PART

SEC. 1159. [42 U.S.C. 1320c-8] Expenses incurred in the administration of the contracts described in section 1862(g) shall be payable from—

(1) funds in the Federal Hospital Insurance Trust Fund; and

(2) funds in the Federal Supplementary Medical Insurance Trust Fund,

in such amounts from each of such Trust Funds as the Secretary shall deem to be fair and equitable after taking into consideration the expenses attributable to the administration of this part with respect to each of such programs. The Secretary shall make such transfers of moneys between such Trust Funds as may be appropriate to settle accounts between them in cases where expenses properly payable from one such Trust Fund have been paid from the other such Trust Fund.

PROHIBITION AGAINST DISCLOSURE OF INFORMATION

SEC. 1160. [42 U.S.C. 1320c-9] (a) An organization, in carrying out its functions under a contract entered into under this part, shall not be a Federal agency for purposes of the provisions of section 552 of title 5, United States Code (commonly referred to as the Freedom of Information Act). Any data or information acquired by any such organization in the exercise of its duties and functions shall be held in confidence and shall not be disclosed to any person except—

(1) to the extent that may be necessary to carry out the purposes of this part,

(2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care, or

(3) in accordance with subsection (b).

(b) An organization having a contract with the Secretary under this part shall provide in accordance with procedures and safeguards established by the Secretary, data and information—

(1) which may identify specific providers or practitioners as may be necessary—

(A) to assist Federal and State agencies recognized by the Secretary as having responsibility for identifying and investigating cases or patterns of fraud or abuse, which data and information shall be provided by the peer review organization to any such agency at the request of such agency relating to a specific case or pattern;

(B) to assist appropriate Federal and State agencies recognized by the Secretary as having responsibility for identifying cases or patterns involving risks to the public health, which data and information shall be provided by the peer review organization to any such agency—

(i) at the discretion of the peer review organization, at the request of such agency relating to a specific case or pattern with respect to which such agency has made a finding, or has a reasonable belief, that there may be a substantial risk to the public health, or

(ii) upon a finding by, or the reasonable belief of, the peer review organization that there may be a substantial risk to the public health;[147]

(C) to assist appropriate State agencies recognized by the Secretary as having responsibility for licensing or certification of providers or practitioners or to assist national accreditation bodies acting pursuant to section 1865 in accrediting providers for purposes of meeting the conditions described in title XVIII, which data and information shall be provided by the peer review organization to any such agency or body at the request of such agency or body relating to a specific case or to a possible pattern of substandard care, but only to the extent that such data and information are required by the agency or body to carry out its respective function which is within the jurisdiction of the agency or body under State law or under section 1865; and[148]

(D) to provide notice to the State medical board in accordance with section 1154(a)(9)(B) when the organization submits a report and recommendations to the Secretary under section 1156(b)(1) with respect to a physician whom the board is responsible for licensing;[149]

(2) to assist the Secretary, and such Federal and State agencies recognized by the Secretary as having health planning or related responsibilities under Federal or State law (including health systems agencies and State health planning and development agencies), in carrying out appropriate health care planning and related activities, which data and information shall be provided in such format and manner as may be prescribed by the Secretary or agreed upon by the responsible Federal and State agencies and such organization, and shall be in the form of aggregate statistical data (without explicitly identifying any individual) on a geographic, institutional, or other basis reflect-

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[147] P.L. 101-508, §4205(d)(1)(B)(i), struck out "and".

[148] P.L. 101-508, §4205(d)(1)(B)(ii), added "and".

[149] P.L. 101-508, §4205(d)(1)(B)(iii), added subparagraph (D), applicable to notices of proposed sanctions issued more than 60 days after November 5, 1990.

ing the volume and frequency of services furnished, as well as the demographic characteristics of the population subject to review by such organization.

The penalty provided in subsection (c) shall not apply to the disclosure of any information received under this subsection, except that such penalty shall apply to the disclosure (by the agency receiving such information) of any such information described in paragraph (1) unless such disclosure is made in a judicial, administrative, or other formal legal proceeding resulting from an investigation conducted by the agency receiving the information. An organization may require payment of a reasonable fee for providing information under this subsection in response to a request for such information.

(c) It shall be unlawful for any person to disclose any such information described in subsection (a) other than for the purposes provided in subsections (a) and (b), and any person violating the provisions of this section shall, upon conviction, be fined not more than $1,000, and imprisoned for not more than 6 months, or both, and shall be required to pay the costs of prosecution.

(d) No patient record in the possession of an organization having a contract with the Secretary under this part shall be subject to subpena or discovery proceedings in a civil action. No document or other information produced by such an organization in connection with its deliberations in making determinations under section 1154(a)(1)(B) or 1156(a)(2) shall be subject to subpena or discovery in any administrative or civil proceeding; except that such an organization shall provide, upon request of a practitioner or other person adversely affected by such a determination, a summary of the organization's findings and conclusions in making the determination.[150]

(e) For purposes of this section and section 1157, the term "organization with a contract with the Secretary under this part" includes an entity with a contract with the Secretary under section 1154(a)(4)(C).

ANNUAL REPORTS

SEC. 1161. [42 U.S.C. 1320c-10] The Secretary shall submit to the Congress not later than April 1 of each year, a full and complete report on the administration, impact, and cost of the program under this part during the preceding fiscal year, including data and information on—

(1) the number, status, and service areas of all utilization and quality control peer review organizations participating in the program;

(2) the number of health care institutions and practitioners whose services are subject to review by such organizations, and the number of beneficiaries and recipients who received services subject to such review during such year;

(3) the various methods of reimbursement utilized in contracts under this part, and the relative efficiency of each such method of reimbursement;

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[150] P.L. 101-508, §4205(e)(1), added this sentence, applicable to all proceedings as of November 5, 1990.

(4) the imposition of penalties and sanctions under this title for violations of law and for failure to comply with the obligations imposed by this part;

(5) the total costs incurred under titles XVIII and XIX of this Act in the implementation and operation of all procedures required by such titles for the review of services to determine their medical necessity, appropriateness of use, and quality; and

(6) descriptions of the criteria upon which decisions are made, and the selection and relative weights of such criteria.

EXEMPTIONS OF CHRISTIAN SCIENCE SANATORIUMS

SEC. 1162. [42 U.S.C. 1320c-11] The provisions of this part shall not apply with respect to a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

MEDICAL OFFICERS IN AMERICAN SAMOA, THE NORTHERN MARIANA ISLANDS, AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS TO BE INCLUDED IN THE UTILIZATION AND QUALITY CONTROL PEER REVIEW PROGRAM

SEC. 1163. [42 U.S.C 1320c-12] For purposes of applying this part to American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands, individuals licensed to practice medicine in those places shall be considered to be physicians and doctors of medicine.

100 PERCENT PEER REVIEW FOR CERTAIN SURGICAL PROCEDURES[151]

SEC. 1164. [42 U.S.C. 1320c-13] (a) 100 PERCENT REVIEW FUNCTION.—

(1) IN GENERAL.—Each utilization and quality control peer review organization shall perform the review described in section 1154(a)(1) for 100 percent of the surgical procedures specified pursuant to subsection (b).

(2) TIMING OF REVIEW.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the review required under paragraph (1) shall be performed—

(i) before the performance of the procedure, in the case of an outpatient procedure, or

(ii) before admission to the hospital for the provision of services in connection with the procedure, in the case of a procedure performed on an inpatient basis.

(B) EXCEPTION.—The review with respect to a procedure need not be performed by the time specified in subparagraph (A) in cases of a medical emergency and under such other circumstances as the Secretary may specify.

(b) SPECIFICATION OF SURGICAL PROCEDURES AND QUALIFIED REVIEWERS.—

(1) IN CONTRACT.—The contract with each organization under this part shall specify at least 10 surgical procedures to be covered under this section.

(2) SELECTION GUIDELINES.—

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[151] See Vol. II, P.L. 99-272, §9401(e), with respect to the study required.

(A) IN GENERAL.—The specification of procedures shall be consistent with selection guidelines established by the Secretary under paragraph (3). The procedures specified shall be included among the surgical procedures which the Secretary has identified as reasonably being able to meet such guidelines.

(B) EXCEPTION.—The Secretary may permit an organization to include among the procedures specified under paragraph (1) procedures not identified by the Secretary under paragraph (2)(A) if to do so would be cost effective and consistent with the criteria described in paragraph (3).

(3) CRITERIA.—The Secretary shall establish such guidelines and identify such surgical procedures consistent with the following criteria:

(A) The procedure is one which generally can be postponed without undue risk to the patient.

(B) The procedure is a high volume procedure among patients who are covered under the programs established under title XVIII or is a high cost procedure.

(C) The procedure has a comparatively high rate of nonconfirmation upon examination by another qualified physician, there is substantial geographic variation in the rates of performance of the procedure, or there are other reasons why pre-procedure review for 100 percent of the procedures would be cost effective.

(4) QUALIFICATIONS FOR PHYSICIANS PROVIDING SECOND OPINIONS.—

(A) IN GENERAL.—The Secretary shall specify, for each procedure identified under paragraphs (2) and (3), the type or types of board certified or board eligible specialists who may conduct a second opinion, required under subsection (c), based upon the nature of the procedure.

(B) FREEDOM OF CHOICE OF PATIENT TO CHOOSE PHYSICIAN.—Subject to subparagraphs (C) and (D), the patient may choose any physician of the proper specialty under subparagraph (A) to provide the second opinion.

(C) PHYSICIANS PROHIBITED FROM PROVIDING SECOND OPINIONS.—For purposes of this section, a second opinion may not be provided by a physician who is affiliated with, or has a common financial interest with, the physician who rendered the first opinion that the procedure was necessary.

(D) RESTRICTED LIST.—In accordance with guidelines of the Secretary, an organization may disqualify a physician from providing a second opinion under this section because of the gross unreliability of the second opinions provided.

(c) REQUIRING A SECOND OPINION IN CERTAIN CASES.—

(1) DETERMINATIONS BY ORGANIZATION.—In the case of a review performed pursuant to subsection (a), the organization shall determine, based on such review, that the surgical procedure—

(A) is reasonable and medically necessary,

(B) is not reasonable and medically necessary, or

(C) may be considered reasonable and necessary, but, because of questions as to the medical appropriateness of performing the procedure, it is appropriate to require the patient to seek a second opinion as to the necessity and appropriateness of performing the procedure before the performance of the procedure.

The Secretary shall develop appropriate measures to ensure that second opinions are only required in situations where a second opinion is needed to resolve outstanding uncertainties as to the medical necessity of the procedure. The organization shall notify, in accordance with section 1154(a)(3), the physician, patient, and hospital or other entity furnishing the service, in the event of a determination under subparagraph (B) or (C) of this paragraph.

(2) PROHIBITION OF PAYMENT IF REQUIRED SECOND OPINION NOT PROVIDED.—No payment may be made under part A or part B of title XVIII with respect to items or services furnished in connection with a surgical procedure for which there is a determination described in paragraph (1)(C), unless the individual undergoing the procedure obtains the second opinion required under that paragraph. The second opinion need not necessarily agree with the first opinion in order for payment to be made.

(3) EXCEPTIONS FOR ELECTIVE SECOND OPINIONS.—Paragraphs (1)(C) and (2) shall not apply to a surgical procedure if—

(A) a delay in providing the procedure would result in a risk to the patient;

(B) no physician is available (within such reasonable limits as the Secretary shall specify) who is (i) qualified to provide the second opinion, and (ii) a participating physician or a physician who has agreed to accept assignment for the second opinion; or

(C) the procedure is to be performed on a patient who is a member of a health maintenance organization or competitive medical plan having a risk-sharing contract with the Secretary under section 1876.

(d) REFERRAL MECHANISM FOR SECOND OPINIONS.—

(1) ACTING AS REFERRAL CENTER.—Each organization shall serve as a referral center for second opinions required under this section.

(2) REFERRAL OF PATIENT.—The organization shall maintain a list of physicians qualified to provide a second opinion and shall advise the patient as to which physicians are participating physicians (within the meaning of section 1842(h)) and which physicians have agreed to accept assignment to perform second opinions. The organization shall assist patients in referral to a qualified physician of the appropriate specialty for purposes of providing the opinion.

(3) FORWARDING OF RELEVANT MEDICAL RECORDS.—Each peer review organization shall, if the patient seeking the second opinion so requests, obtain the relevant medical records from the physician who rendered the first opinion that the procedure was necessary, and provide the relevant information to the physician selected by the patient to render the second opinion.

(e) NOTICE TO PHYSICIANS, HOSPITALS, AND BENEFICIARIES.—The Secretary shall assure that notice is provided to physicians, hospitals, rural primary care hospitals,[152] ambulatory surgical centers, and beneficiaries respecting the activities under this section, including the applicable list of surgical procedures specified under this section.

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[152] P.L. 101-239, §6003(g)(3)(D)(v), inserted "rural primary care hospitals,", effective December 19, 1989.

TITLE XII—ADVANCES TO STATE UNEMPLOYMENT FUNDS[1]

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ADVANCES TO STATE UNEMPLOYMENT FUNDS[3]

SECTION 1201. [42 U.S.C. 1321] (a)(1) Advances shall be made to the States from the Federal unemployment account in the Unemployment Trust Fund as provided in this section, and shall be repayable, with interest to the extent provided in section 1202(b), in the manner provided in sections 901(d)(1), 903(b)(2), and 1202. An advance to a State for the payment of compensation in any 3-month period may be made if—

(A) the Governor of the State applies therefor no earlier than the first day of the month preceding the first month of such 3-month period, and

(B) he furnishes to the Secretary of Labor his estimate of the amount of an advance which will be required by the State for the payment of compensation in each month of such 3-month period.

(2) In the case of any application for an advance under this section to any State for any 3-month period, the Secretary of Labor shall—

(A) determine the amount (if any) which he finds will be required by such State for the payment of compensation in each month of such 3-month period, and

(B) certify to the Secretary of the Treasury the amount (not greater than the amount estimated by the Governor of the State) determined under subparagraph (A).

The aggregate of the amounts certified by the Secretary of Labor with respect to any 3-month period shall not exceed the amount which the Secretary of the Treasury reports to the Secretary of Labor is available in the Federal unemployment account for advances with respect to each month of such 3-month period.

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[1] Title XII of the Social Security Act is administered by the Department of Labor.

Title XII appears in the United States Code as §§1321-1324, subchapter XII, chapter 7, Title 42.

Regulations of the Secretary of Labor relating to Title XII are contained in chapter V, Title 20, Code of Federal Regulations.

[2] This table of contents does not appear in the law.

[3] See P.L. 83-591, §3302(c)(3)(this volume), with respect to advances to a State or State agency.

See Vol. II, P.L. 95-521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 96-499, §1025, with respect to withholding certification of State unemployment laws.

(3) For purposes of this subsection—

(A) an application for an advance shall be made on such forms, and shall contain such information and data (fiscal and otherwise) concerning the operation and administration of the State unemployment compensation law, as the Secretary of Labor deems necessary or relevant to the performance of his duties under this title,

(B) the amount required by any State for the payment of compensation in any month shall be determined with due allowance for contingencies and taking into account all other amounts that will be available in the State's unemployment fund for the payment of compensation in such month, and

(C) the term "compensation" means cash benefits payable to individuals with respect to their unemployment, exclusive of expenses of administration.

(b) The Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, transfer in monthly installments from the Federal unemployment account to the account of the State in the Unemployment Trust Fund the amount certified under subsection (a) by the Secretary of Labor (but not exceeding that portion of the balance in the Federal unemployment account at the time of the transfer which is not restricted as to use pursuant to section 903(b)(1)). The amount of any monthly installment so transferred shall not exceed the amount estimated by the State to be required for the payment of compensation for the month with respect to which such installment is made.

REPAYMENT BY STATES OF ADVANCES TO STATE UNEMPLOYMENT FUNDS

SEC. 1202. [42 U.S.C. 1322] (a) The Governor of any State may at any time request that funds be transferred from the account of such State to the Federal unemployment account in repayment of part or all of that balance of advances, made to such State under section 1201, specified in the request. The Secretary of Labor shall certify to the Secretary of the Treasury the amount and balance specified in the request; and the Secretary of the Treasury shall promptly transfer such amount in reduction of such balance.

(b)(1) Except as otherwise provided in this subsection, each State shall pay interest on any advance made to such State under section 1201. Interest so payable with respect to periods during any calendar year shall be at the rate determined under paragraph (4) for such calendar year.

(2) No interest shall be required to be paid under paragraph (1) with respect to any advance or advances made during any calendar year if—

(A) such advances are repaid in full before the close of September 30 of the calendar year in which the advances were made, and

(B) no other advance was made to such State under section 1201 during such calendar year and after the date on which the repayment of the advances was completed.

(3)(A) Interest payable under paragraph (1) which was attributable to periods during any fiscal year shall be paid by the State to the Secretary of the Treasury prior to the first day of the following fiscal year. If interest is payable under paragraph (1) on any advance (hereinafter in this subparagraph referred to as the "first advance") by reason of another advance made to such State after September 30 of the calendar year in which the first advance was made, interest on such first advance attributable to periods before such September 30 shall be paid not later than the day after the date on which the other advance was made.

(B) Notwithstanding subparagraph (A), in the case of any advance made during the last 5 months of any fiscal year, interest on such advance attributable to periods during such fiscal year shall not be required to be paid before the last day of the succeeding taxable year. Any interest the time for payment of which is deferred by the preceding sentence shall bear interest in the same manner as if it were an advance made on the day on which it would have been required to be paid but for this subparagraph.

(C)(i) In the case of any State which meets the requirements of clause (ii) for any calendar year, any interest otherwise required to be paid under this subsection during such calendar year shall be paid as follows—

(I) 25 percent of the amount otherwise required to be paid on or before any day during such calendar year shall be paid on or before such day; and

(II) 25 percent of the amount otherwise required to be paid on or before such day shall be paid on or before the corresponding day in each of the 3 succeeding calendar years.

No interest shall accrue on such deferred interest.

(ii) A State meets the requirements of this clause for any calendar year if the rate of insured unemployment (as determined for purposes of section 203 of the Federal-State Extended Unemployment Compensation Act of 1970[4]) under the State law of the period consisting of the first 6 months of the preceding calendar year equaled or exceeded 7.5 percent.

(4) The interest rate determined under this paragraph with respect to any calendar year is a percentage (but not in excess of 10 percent) determined by dividing—

(A) the aggregate amount credited under section 904(e) to State accounts on the last day of the last calendar quarter of the immediately preceding calendar year, by

(B) the aggregate of the average daily balances of the State accounts for such quarter as determined under section 904(e).

(5) Interest required to be paid under paragraph (1) shall not be paid (directly or indirectly) by a State from amounts in its unemployment fund. If the Secretary of Labor determines that any State action results in the paying of such interest directly or indirectly (by an equivalent reduction in State unemployment taxes or otherwise) from such unemployment fund, the Secretary of Labor shall not certify such State's unemployment compensation law under section 3304 of the Internal Revenue Code of 1954[5]. Such noncertification shall be made in accordance with section 3304(c) of such Code.

(6)(A) For purposes of paragraph (2), any voluntary repayment shall be applied against advances made under section 1201 on the last made first repaid basis. Any other repayment of such an advance shall be applied against advances on a first made first repaid basis.

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[4] P.L. 91-373, Title II.

[5] See P.L. 83-591, §3304 (this volume).

(B) For purposes of this paragraph, the term "voluntary repayment" means any repayment made under subsection (a).

(7) This subsection shall only apply to advances made on or after April 1, 1982.

(8)(A) With respect to interest due under this section on September 30 of 1983, 1984, or 1985 (other than interest previously deferred under paragraph (3)(C)), a State may pay 80 percent of such interest in four annual installments of at least 20 percent beginning with the year after the year in which it is otherwise due, if such State meets the criteria of subparagraph (B). No interest shall accrue on such deferred interest.

(B) To meet the criteria of this subparagraph a State must—

(i) have taken no action since October 1, 1982, which would reduce its net unemployment tax effort or the net solvency of its unemployment system (as determined for purposes of section 3302(f) of the Internal Revenue Code of 1954[6]); and

(ii)(I) have taken an action (as certified by the Secretary of Labor) after March 31, 1982, which would have increased revenue liabilities and decreased benefits under the State's unemployment compensation system (hereinafter referred to as a "solvency effort") by a combined total of the applicable percentage (as compared to such revenues and benefits as would have been in effect without such State action) for the calendar year for which the deferral is requested; or

(II) have had, for taxable year 1982, an average unemployment tax rate which was equal to or greater than 2.0 percent of the total of the wages (as determined without any limitation on amount) attributable to such State subject to contribution under the State unemployment compensation law with respect to such taxable year.

In the case of the first year for which there is a deferral (over a 4-year period) of the interest otherwise payable for such year, the applicable percentage shall be 25 percent. In the case of the second such year, the applicable percentage shall be 35 percent. In the case of the third such year, the applicable percentage shall be 50 percent.

(C)(i) The base year is the first year for which deferral under this provision is requested and subsequently granted. The Secretary of Labor shall estimate the unemployment rate for the base year. To determine whether a State meets the requirements of subparagraph (B)(ii)(I), the Secretary of Labor shall determine the percentage by which the benefits and taxes in the base year with the application of the action referred to in subparagraph (B)(ii)(I) are lower or greater, as the case may be, than such benefits and taxes would have been without the application of such action. In making this determination, the Secretary shall deem the application of the action referred to in subparagraph (B)(ii)(I) to have been effective for the base year to the same extent as such action is effective for the year following the year for which the deferral is sought. Once a deferral is approved under clause (ii)(I) of subparagraph (B) a State must continue to maintain its solvency effort. Failure to do so shall result in the State being required to make immediate payment of all deferred interest.

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[6] See P.L. 83-591, §3302(f) (this volume).

(ii) Increases in the taxable wage base from $6,000 to $7,000 or increases after 1984 in the maximum tax rate to 5.4 percent shall not be counted for purposes of meeting the requirement of subparagraph (B).

(D) In the case of a State which produces a solvency effort of 50 percent, 80 percent, and 90 percent rather than the 25 percent, 35 percent, and 50 percent required under subparagraph (B), the interest shall be computed at an interest rate which is 1 percentage point less than the otherwise applicable interest rate.

(9) Any interest otherwise due from a State on September 30 of a calendar year after 1982 may be deferred (and no interest shall accrue on such deferred interest) for a grace period of not to exceed 9 months if, for the most recent 12-month period for which data are available before the date such interest is otherwise due, the State had an average total unemployment rate of 13.5 percent or greater.

(c) Interest paid by States in accordance with this section shall be credited to the Federal unemployment account established by section 904(g) in the Unemployment Trust Fund.

ADVANCES TO FEDERAL UNEMPLOYMENT ACCOUNT

SEC. 1203. [42 U.S.C. 1323] There are hereby authorized to be appropriated to the Federal unemployment account, as repayable advances, such sums as may be necessary to carry out the purposes of this title. Amounts appropriated as repayable advances shall be repaid by transfers from the Federal unemployment account to the general fund of the Treasury, at such times as the amount in the Federal unemployment account is determined by the Secretary of the Treasury, in consultation with the Secretary of Labor, to be adequate for such purpose. Any amount transferred as a repayment under this section shall be credited against, and shall operate to reduce, any balance of advances repayable under this section. Whenever, after the application of sections 901(f)(3) and 902(a) with respect to the excess in the employment security administration account as of the close of any fiscal year, there remains any portion of such excess, so much of such remainder as does not exceed the balance of advances made pursuant to this section shall be transferred to the general fund of the Treasury and shall be credited against, and shall operate to reduce, such balance of advances. Amounts appropriated as repayable advances for purposes of this subsection shall bear interest at a rate equal to the average rate of interest, computed as of the end of the calendar month next preceding the date of such advance, borne by all interest bearing obligations of the United States then forming part of the public debt; except that in cases in which such average rate is not a multiple of one-eighth of 1 percent, the rate of interest shall be the multiple of one-eighth of 1 percent next lower than such average rate.

DEFINITION OF GOVERNOR

SEC. 1204. [42 U.S.C. 1324] When used in this title, the term "Governor" includes the Commissioners of the District of Columbia.

[TITLE XIII—RECONVERSION UNEMPLOYMENT BENEFITS FOR SEAMEN][1]

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[1] P.L. 79-719 (60 Stat. 978, approved August 10, 1946), §306, added this title.

P.L. 98-369, §2663(f), repealed Title XIII, effective July 18, 1984, but this amendment shall not be construed as changing or affecting any right, liability, status, or interpretation which existed under this provision before that date.

[TITLE XIV—GRANTS TO STATES FOR AID TO THE PERMANENTLY AND TOTALLY DISABLED][1]

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APPROPRIATION

SECTION 1401. [42 U.S.C. 1351] For the purpose of enabling each State to furnish financial assistance, as far as practicable under the conditions in such State, to needy individuals eighteen years of age and older who are permanently and totally disabled, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Administrator, State plans for aid to the permanently and totally disabled.

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[1] P.L. 92-603, §303, *repealed* Title XIV, effective January 1, 1974, *except* with respect to Puerto Rico, Guam, and the Virgin Islands. The Commonwealth of the Northern Marianas may elect to initiate a Title XIV social services program if it chooses; see P.L. 94-241, [Covenant to Establish a Commonwealth of the Northern Marianas], Vol. II.

Title XIV of the Social Security Act is administered by the Department of Health and Human Services (formerly the Department of Health, Education, and Welfare). The Office of Family Assistance, Family Support Administration, administers benefit payments under Title XIV. The Office of Human Development Services administers social services under Title XIV.

Title XIV appears in the United States Code as §§1351-1355, subchapter XIV, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services relating to Title XIV are contained in chapter 1, Title 42, and subtitle A and chapter XIII, Title 45, Code of Federal Regulations.

See Vol. II, 31 U.S.C. 6504-6505 with respect to intergovernmental cooperation.

See Vol. II, 31 U.S.C. 7501-7507 with respect to uniform audit requirements for State and local governments receiving Federal financial assistance.

See Vol. II, P.L. 82-183, §618, for the "Jenner Amendment", which prohibits denial of grants-in-aid under certain conditions.

See Vol. II, P.L. 88-352, §601, for prohibition against discrimination in Federally assisted programs.

See Vol. II, P.L. 89-97, §121(b), with respect to restrictions on payment to a State receiving payments under Title XIX.

See Vol. II, P.L. 95-521, §102(i), with respect to reporting of benefits received under the Social Security Act.

[2] This table of contents does not appear in the law.

STATE PLANS FOR AID TO THE PERMANENTLY AND TOTALLY DISABLED

SEC. 1402. [42 U.S.C. 1352] (a) A State plan for aid to the permanently and totally disabled must (1) except to the extent permitted by the Secretary with respect to services, provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them; (2) provide for financial participation by the State; (3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan; (4) provide (A) for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid to the permanently and totally disabled is denied or is not acted upon with reasonable promptness, and (B) that if the State plan is administered in each of the political subdivisions of the State by a local agency and such local agency provides a hearing at which evidence may be presented prior to a hearing before the State agency, such local agency may put into effect immediately upon issuance its decision upon the matter considered at such hearing; (5) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan[3], and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency; (6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports; (7) provide that no aid will be furnished any individual under the plan with respect to any period with respect to which he is receiving old-age assistance under the State plan approved under section 2 of this Act, aid to families with dependent children under the State plan approved under section 402 of this Act, or aid to the blind under the State plan approved under section 1002 of this Act; (8) provide that the State agency shall, in determining need, take into consideration any other income and resources of an individual claiming aid to the permanently and totally disabled, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination, (A) the State agency may disregard not more than $7.50 of any income, (B) of the first $80 per month of additional income which is earned the State agency may disregard not more than the first $20 thereof plus one-half of the remainder, and (C) the State agency may, for a period not in excess of 36 months, disregard such additional amounts of other income and resources, in the case of an individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan, but only with respect to the part or parts of such period during substantially all of which he is actually undergoing vocational rehabilitation;[4] (9) provide safeguards which

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[3] P.L. 91-648, §208(a)(3)(D), transferred to the U.S. Civil Service Commission, effective March 6, 1971, all powers, functions, and duties of the Secretary under subparagraph (A).

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[4] See Vol. II, 10 U.S.C. 2546 with respect to shelter for the homeless at military installations.

See Vol. II, P.L. 81-171, §521(a)(1)(E), with respect to exclusion from income and resources of certain assistance rendered to provide occupant-owned, rental and cooperative housing.

See Vol. II, P.L. 87-543, §141(b), with respect to ineligibility to receive payments under Title XIV where payments have been made under Title XVI.

See Vol. II, P.L. 88-525, §8(b), with respect to exclusion from income and resources of the value of food stamps.

See Vol. II, P.L. 89-73, §210(b), with respect to exclusion from income of the costs of any project under that act.

See Vol. II, P.L. 89-329, §479B, with respect to exclusion from income or resources of certain student financial assistance.

See Vol. II, P.L. 90-248, §248(c), effective July 1, 1969, with respect to income disregards applicable to Guam, Puerto Rico, and the Virgin Islands.

See Vol. II, P.L. 91-646, §216, with respect to exclusion from income of payments made under that act.

See Vol. II, P.L. 93-112, §613(c), for the conditional exclusion from income of wages, allowances, transportation reimbursement, and attendant care provided to handicapped individuals under community service employment pilot programs.

See Vol. II, P.L. 93-113, §404(g), with respect to exclusion from income and resources of payments to volunteers under that act.

See Vol. II, P.L. 93-134, §§7 and 8, with respect to exclusion from income and resources of certain judgment funds to any Indian tribe.

See Vol. II, P.L. 93-288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 94-114, §6, with respect to exclusion from income and resources of property and receipts from submarginal land to certain Indians.

See Vol. II, P.L. 95-433, §2, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 95-498, §6, with respect to an income and resources exclusion applicable to the Pueblo of Santa Ana Indians, New Mexico.

See Vol. II, P.L. 95-499, §6, with respect to an income and resources exclusion applicable to the Pueblo of Zia Indians, New Mexico.

See Vol. II, P.L. 95-557, §410(b), with respect to exclusion from income of services (but not of wages) provided to a public housing resident or to a resident of a housing project assisted under the "Housing Act of 1959" (see Vol. II, P.L. 86-372, §202).

See Vol. II, P.L. 97-35, §2605(f), with respect to exclusion from income and resources of home energy assistance payments or allowances.

See Vol. II, P.L. 98-64, §2(a), with respect to exclusion from income and resources of per capita payments to Indians.

See Vol. II, P.L. 98-432, §5(e), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98-500, §8, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98-602, §106(d), with respect to exclusion from income and resources of certain funds distributed per capita.

See Vol. II, P.L. 99-130, §8, with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99-146, §6(b), with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99-264, §16, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99-346, §6(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99-377, §4(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 100-139, §4(h)(6), with respect to exclusion of benefits as basis for denial of eligibility.

See Vol. II, P.L. 100-407, §105(c), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100-409, §5, with respect to the effect of this Act on P.L. 92-203 or P.L. 96-487.

See Vol. II, P.L. 100-411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100-581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 101-41, §10(b)-(d), with respect to eligibility for Federal programs and treatment of funds, assets, and income.

See Vol. II, P.L. 101-42, §3, with respect to the restoration of Federal recognition, rights, and privileges.

See Vol. II, P.L. 101-201, with respect to Agent Orange settlement payments.

See Vol. II, P.L. 101-239, §10405, with respect to Agent Orange settlement payments excluded permit the use or disclosure of information concerning applicants or recipients only (A) to public officials who require such information in connection with their official duties, or (B) to other persons for purposes directly connected with the administration of the State plan;[5] (10) provide that all individuals wishing to make application for aid to the permanently and totally disabled shall have opportunity to do so, and that aid to the permanently and totally disabled shall be furnished with reasonable promptness to all eligible individuals; (11) effective July 1, 1953, provide, if the plan includes payments to individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions; (12) provide a description of the services (if any) which the State agency makes available (using whatever internal organizational arrangement it finds appropriate for this purpose) to applicants for and recipients of aid to the permanently and totally disabled to help them attain self-support or self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services; and (13) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act.

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for aid to the permanently and totally disabled under the plan—

(1) Any residence requirement which excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for aid to the permanently and totally disabled and has resided therein continuously for one year immediately preceding the application;

(2) Any citizenship requirement which excludes any citizen of the United States.

At the option of the State, the plan may provide that manuals and other policy issuances will be furnished to persons without charge for the reasonable cost of such materials, but such provision shall not be required by the Secretary as a condition for the approval of such plan under this title.

PAYMENT TO STATES

SEC. 1403. [42 U.S.C. 1353] (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid to the permanently and totally disabled, for each quarter, beginning with the quarter commencing October 1, 1958—

[(1) Stricken.[6]]

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended

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from countable income and resources under Federal means-tested programs.

See Vol. II, P.L. 101-277, §8(b), with respect to exclusion, from income or resources, of funds held in trust or distributed to Seminole Indians.

[5] See Vol. II, P.L. 82-183, §618, for the "Jenner Amendment", with respect to denial of grants-in-aid under certain conditions.

[6] P.L. 97-35, §2184(c)(2)(A); 95 Stat. 817.

during such quarter as aid to the permanently and totally disabled under the State plan, not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of aid to the permanently and totally disabled for such month; and

(3) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and official administration of the State plan—

(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

(B) 100 percent of so much of such expenditures as are for the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus

(C) one-half of the remainder of such expenditures.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Administrator shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of permanently and totally disabled individuals in the State, and (C) such other investigation as the Administrator may find necessary.

(2) The Administrator shall then certify to the Secretary of the Treasury the amount so estimated by the Administrator, (A) reduced or increased, as the case may be, by any sum by which he finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter, and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Administrator, of the net amount recovered during a prior quarter by the State or any political subdivision thereof with respect to aid to the permanently and totally disabled furnished under the State plan; except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Administrator for such prior quarter: *Provided,* That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount

expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause[7] (B) of this paragraph.[8]

(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department, and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Administrator, the amount so certified.[9]

OPERATION OF STATE PLANS

SEC. 1404. [42 U.S.C. 1354] In the case of any State plan for aid to the permanently and totally disabled which has been approved by the Secretary of Health, Education, and Welfare, if the Secretary after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds—

(1) that the plan has been so changed as to impose any residence or citizenship requirement prohibited by section 1402(b), or that -in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or

(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 1402(a) to be included in the plan;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) until he is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

DEFINITION

SEC. 1405. [42 U.S.C. 1355] For the purposes of this title, the term "aid to the permanently and totally disabled" means money payments to needy individuals eighteen years of age or older who are permanently and totally disabled, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual who is a patient in an institution for tuberculosis or mental diseases. Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1402 includes provision for—

(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such

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[7] As in original. Possibly, should be "subparagraph".
[8] Alignment as in original.
[9] Alignment as in original.

inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the permanently and totally disabled to be paid (and in conjunction with other income and resources), meet all the need[10] of the individuals with respect to whom such payments are made;

(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made.

At the option of a State (if its plan approved under this title so provides), such term (i) need not include money payments to an individual who has been absent from such State for a period in excess of ninety consecutive days (regardless of whether he has maintained his residence in such State during such period) until he has been present in such State for thirty consecutive days in the case of such an individual who has maintained his residence in such State during such period or ninety consecutive days in the case of any other such individual, and (ii) may include rent payments made directly to a public housing agency on behalf of a recipient or a group or groups of recipients of aid under such plan.

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[10] As in original. Should be "needs".

[TITLE XV—UNEMPLOYMENT COMPENSATION FOR FEDERAL EMPLOYEES][1]

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[1] P.L. 83-767 (68 Stat. 1130, approved September 1, 1954), §4(a), added Title XV to the Social Security Act.

P.L. 89-554 (80 Stat. 378, approved September 6, 1966), §8, repealed Title XV. See 5 U.S.C. 8501 et seq.

[TITLE XVI—GRANTS TO STATES FOR AID TO THE AGED, BLIND, OR DISABLED][1]

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APPROPRIATION

SECTION 1601. [42 U.S.C. 1381 note] For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish financial assistance to needy individuals who are 65 years of age or over, are blind, or are 18 years of age or over and permanently and totally disabled, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for aid to the aged, blind, or disabled.

STATE PLANS FOR AID TO THE AGED, BLIND, OR DISABLED

SEC. 1602. [42 U.S.C. 1382 note] (a) A State plan for aid to the aged, blind, or disabled, must—

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[1] This Title XVI of the Social Security Act is administered by the Department of Health and Human Services (formerly the Department of Health, Education, and Welfare). The Office of Family Assistance, Family Support Administration, administers benefit payments under this Title XVI. The Office of Human Development Services administers social services under this Title XVI.

This Title XVI appears in the United States Code as §§1381 note-1385 note, subchapter XVI, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services with respect to this Title XVI are contained in subtitle A and chapter XIII, Title 45, Code of Federal Regulations.

P.L. 92-603, §§301 and 303, *repealed* this title effective January 1, 1974, except with respect to Guam, Puerto Rico, and the Virgin Islands. The Commonwealth of the Northern Marianas may elect to initiate a Title XVI social services program if it chooses.

See Vol. II, 31 U.S.C. 6504-6505 with respect to intergovernmental cooperation.

See Vol. II, 31 U.S.C. 7501-7507 with respect to uniform audit requirements for State and local governments receiving Federal financial assistance.

See Vol. II, P.L. 82-183, §618, for the "Jenner Amendment", with respect to prohibition against denial of grants-in-aid under certain conditions.

See Vol. II, P.L. 88-352, §601, with respect to prohibition against discrimination in federally assisted programs.

See Vol. II, P.L. 89-97, §121(b), with respect to restrictions on payment to a State receiving payments under Title XIX.

See Vol. II, P.L. 95-521, §102(i), with respect to reporting of benefits received under the Social Security Act.

[2] This table of contents does not appear in the law.

(1) except to the extent permitted by the Secretary with respect to services, provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State;

(3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan;

(4) provide (A) for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid or assistance under the plan is denied or is not acted upon with reasonable promptness, and (B) that if the State plan is administered in each of the political subdivisions of the State by a local agency and such local agency provides a hearing at which evidence may be presented prior to a hearing before the State agency, such local agency may put into effect immediately upon issuance its decision upon the matter considered at such hearing;

(5) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan[3], and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which permit the use or disclosure of information concerning applicants or recipients only (A) to public officials who require such information in connection with their official duties, or (B) to other persons for purposes directly connected with the administration of the State plan;

(8) provide that all individuals wishing to make application for aid or assistance under the plan shall have opportunity to do so, and that such aid or assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide, if the plan includes aid or assistance to or on behalf of individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions;

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[3] P.L. 91-648, §208(a)(3)(D), transferred to the U.S. Civil Service Commission, effective March 6, 1971, all powers, functions, and duties of the Secretary under subparagraph (A).

(10) provide a description of the services (if any) which the State agency makes available (using whatever internal organizational arrangement it finds appropriate for this purpose) to applicants for or recipients of aid or assistance under the plan to help them attain self-support or self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services;

(11) provide that no aid or assistance will be furnished any individual under the plan with respect to any period with respect to which he is receiving assistance under the State plan approved under title I or aid under the State plan approved under part A of title IV or under title X or XIV;

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) include reasonable standards, consistent with the objectives of this title, for determining eligibility for and the extent of aid or assistance under the plan;

(14) provide that the State agency shall, in determining need for aid to the aged, blind, or disabled, take into consideration any other income and resources of an individual claiming such aid, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination with respect to any individual—

(A) if such individual is blind, the State agency (i) shall disregard the first $85 per month of earned income plus one-half of earned income in excess of $85 per month, and (ii) shall, for a period not in excess of 12 months, and may, for a period not in excess of 36 months, disregard such additional amounts of other income and resources, in the case of any such individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan,

(B) if such individual is not blind but is permanently and totally disabled, (i) of the first $80 per month of earned income, the State agency may disregard not more than the first $20 thereof plus one-half of the remainder, and (ii) the State agency may, for a period not in excess of 36 months, disregard such additional amounts of other income and resources, in the case of any such individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan, but only with respect to the part or parts of such period during substantially all of which he is actually undergoing vocational rehabilitation,

(C) if such individual has attained age 65 and is neither blind nor permanently and totally disabled, of the first $80 per month of earned income the State agency may disregard not more than the first $20 thereof plus one-half of the remainder, and

(D) the State agency may, before disregarding the amounts referred to above in this paragraph (14), disregard not more than $7.50 of any income;[4] and

(15) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act.

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[4] See Vol. II, 10 U.S.C. 2546 with respect to shelter for the homeless at military installations.

See Vol. II, P.L. 81-171, §521(a)(1)(E), with respect to exclusion from income and resources of certain assistance rendered to provide occupant-owned, rental and cooperative housing.

See Vol. II, P.L. 88-525, §8, with respect to the exclusion from income and resources of the value of food stamps.

See Vol. II, P.L. 89-73, §210(b), with respect to exclusion from income of the costs of any project under that act.

See Vol. II, P.L. 89-329, §479B, with respect to exclusion from income or resources of certain student financial assistance.

See Vol. II, P.L. 90-248, §248(c), effective July 1, 1969, with respect to income disregards applicable to Guam, Puerto Rico, and the Virgin Islands.

See Vol. II, P.L. 91-646, §216, with respect to exclusion from income of payments made.

See Vol. II, P.L. 93-112, §613(c), with respect to conditional exclusion of wages, allowances, transportation reimbursement, and attendant care costs.

See Vol. II, P.L. 93-113, §404(g), with respect to the exclusion from income and resources of payments to volunteers.

See Vol. II, P.L. 93-134, §§7 and 8, with respect to exclusion from income and resources of certain judgment funds to any Indian tribe.

See Vol. II, P.L. 93-288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 94-114, §6, with respect to exclusion from income and resources of property and receipts from submarginal land to certain Indians.

See Vol. II, P.L. 95-433, §2, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 95-498, §6, with respect to an income and resources exclusion applicable to the Pueblo of Santa Ana Indians, New Mexico.

See Vol. II, P.L. 95-499, §6, with respect to an income and resources exclusion applicable to the Pueblo of Zia Indians, New Mexico.

See Vol. II, P.L. 95-557, §410(b), with respect to exclusion from income of services (but not of wages) provided to a public housing resident or to a resident of a housing project assisted under the "Housing Act of 1959" (See Vol. II, P.L. 86-372, §202.).

See Vol. II, P.L. 97-35, §2605(f), with respect to exclusion from income and resources of home energy assistance payments or allowances.

See Vol. II, P.L. 98-64, §2(a), with respect to exclusion from income and resources of per capita payments to Indians.

See Vol. II, P.L. 98-432, §5(e), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98-500, §8, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98-602, §106(d), with respect to exclusion from income and resources of certain funds distributed per capita.

See Vol. II, P.L. 99-130, §8, with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99-146, §6(b), with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99-264, §16, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99-346, §6(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99-377, §4(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 100-139, §4(h)(6), with respect to exclusion of benefits as basis for denial of eligibility.

See Vol. II, P.L. 100-407, §105(c), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100-409, §5, with respect to the effect of this Act on P.L. 92-203 or P.L. 96-487.

See Vol. II, P.L. 100-411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100-581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 101-41, §10(b)-(d), with respect to eligibility for Federal programs and treatment of funds, assets, and income.

See Vol. II, P.L. 101-42, §3, with respect to the restoration of Federal recognition, rights, and privileges.

See Vol. II, P.L. 101-201, with respect to Agent Orange settlement payments.

See Vol. II, P.L. 101-239, §10405, with respect to Agent Orange settlement payments excluded from countable income and resources under Federal means-tested programs.

See Vol. II, P.L. 101-277, §8(b), with respect to exclusion, from income or resources, of funds held in trust or distributed to Seminole Indians.

Notwithstanding paragraph (3), if on January 1, 1962, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X was different from the State agency which administered or supervised the administration of the plan of such State approved under title I and the State agency which administered or supervised the administration of the plan of such State approved under title XIV, the State agency which administered or supervised the administration of such plan approved under title X may be designated to administer or supervise the administration of the portion of the State plan for aid to the aged, blind, or disabled which relates to blind individuals and a separate State agency may be established or designated to administer or supervise the administration of the rest of such plan; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title.

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for aid or assistance under the plan—

(1) an age requirement of more than sixty-five years; or

(2) any residence requirement which excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for such aid and has resided therein continuously for one year immediately preceding the application,[5]; or

(3) any citizenship requirement which excludes any citizen of the United States.

At the option of the State, the plan may provide that manuals and other policy issuances will be furnished to persons without charge for the reasonable cost of such materials, but such provision shall not be required by the Secretary as a condition for the approval of such plan under this title. In the case of any State to which the provisions of section 344 of the Social Security Act Amendments of 1950[6] were applicable on January 1, 1962, and to which the sentence of section 1002(b) following paragraph (2) thereof is applicable on the date on which its State plan for aid to the aged, blind, or disabled was submitted for approval under this title, the Secretary shall approve the plan of such State for aid to the aged, blind, or disabled for purposes of this title, even though it does not meet the requirements of paragraph (14) of subsection (a), if it meets all other requirements of this title for an approved plan for aid to the aged, blind, or disabled; but payments under section 1603 shall be made, in the case of any such plan, only with respect to expenditures thereunder which would be included as expenditures for the purposes of section 1603 under a plan approved under this section without regard to the provisions of this sentence.

(c) Subject to the last sentence of subsection (a), nothing in this title shall be construed to permit a State to have in effect with respect to any period more than one State plan approved under this title.

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[5] As in original. Comma should be stricken.

[6] P.L. 87-543, §136(b), [76 Stat. 197], repealed §344, effective July 25, 1962.

PAYMENTS TO STATES

SEC. 1603. [42 U.S.C. 1383 note] (a) From the sums appropriated therefor, the Secretary shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing October 1, 1962—

[(1) Stricken.[7]]

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to—

(A) one-half of the total of the sums expended during such quarter as aid to the aged, blind, or disabled under the State plan, not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of aid to the aged, blind, or disabled for such month; plus

(B) one-half of the amount by which such expenditures exceed the maximum which may be counted under clause[8] (A), not counting so much of any expenditure with respect to any month as exceeds the product of $45 multiplied by the total number of such recipients of aid to the aged, blind, or disabled for such month; and

[(3) Stricken.[9]]

(4) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health and Human Services for the proper and efficient administration of the State plan—

(A) 75 per centum of so much of such expenditures as are for the training (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions) of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

(B) 100 percent of so much of such expenditures as are for the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus

(C) one-half of the remainder of such expenditures.

(b)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

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[7] P.L. 97-35, §2184(d)(5)(A); 95 Stat. 818.

[8] As in original. Possibly, should be "subparagraph".

[9] P.L. 97-35, §2184(d)(5)(A); 95 Stat. 818.

(2) The Secretary shall then pay, in such installments as he may determine, to the State the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to aid or assistance furnished under the State plan, but excluding any amount of such aid or assistance recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased, shall be considered an overpayment to be adjusted under this subsection.

(4) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

OPERATION OF STATE PLANS

SEC. 1604. [42 U.S.C. 1384 note] If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1602; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

DEFINITIONS

SEC. 1605. [42 U.S.C. 1385 note] (a)[10] For purposes of this title, the term "aid to the aged, blind, or disabled" means money payments to needy individuals who are 65 years of age or older, are blind, or are 18 years of age or over and permanently and totally disabled, but such term does not include—

(1) any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(2) any such payments to or care in behalf of any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1602 includes provision for—

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[10] As in original; "(a)" should be stricken.

(A) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

(B) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the aged, blind, or disabled to be paid (and in conjunction with other income and resources), meet all the need[11] of the individuals with respect to whom such payments are made;

(C) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

(D) periodic review by such State agency of the determination under clause[12] (A) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

(E) opportunity for a fair hearing before the State agency on the determination referred to in clause[13] (A) for any individual with respect to whom it is made.

At the option of a State (if its plan approved under this title so provides), such term (i) need not include money payments to an individual who has been absent from such State for a period in excess of ninety consecutive days (regardless of whether he has maintained his residence in such State during such period) until he has been present in such State for thirty consecutive days in the case of such an individual who has maintained his residence in such State during such period or ninety consecutive days in the case of any other such individual, and (ii) may include rent payments made directly to a public housing agency on behalf of a recipient or a group or groups of recipients of aid under such plan.

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[11] As in original. Should be "needs".

[12] As in original. Possibly, should be "subparagraph".

[13] As in original. Possibly, should be "subparagraph".

TITLE XVI—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED[1]

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[1] This Title XVI of the Social Security Act is administered by the Social Security Administration, Department of Health and Human Services (formerly Department of Health, Education, and Welfare).

This Title XVI appears in the United States Code as §§1381-1383d, subchapter XVI, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services with respect to this Title XVI are contained in chapter III, Title 20, Code of Federal Regulations.

See Vol. II, 31 U.S.C. 3720 and 3720A, with respect to collection of payments due to Federal agencies .

See Vol. II, P.L. 88-525, §11(i), with respect to the acceptance by social security offices of applications for participation in the food stamp program from recipients of supplemental security income.

P.L. 94-241, §1 (§502 of Covenant), approved March 24, 1976, provides that this Title XVI is applicable to the Northern Mariana Islands, except as otherwise provided. Effective 11 A.M. of January 9, 1978, Northern Mariana Islands local time (Presidential Proclamation 4534, signed October 24, 1977; 42 FR 56593, October 27, 1977).

See Vol. II, P.L. 95-521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 96-223, §102, with respect to allocation of funds for programs to assist SSI recipients.

See Vol. II, P.L. 97-300, §106(e)(2), with respect to performance standards; §202(b)(3)(B), with respect to governors' incentive grants; and §§501-505, with respect to the payment of a bonus for the successful job placement of certain employable dependent individuals.

See Vol. II, P.L. 100-203, §9111(b), with respect to a study of notices provided to blind individuals; §9116(b) and §9116(c), with respect to retention of medicaid when SSI benefits are lost upon entitlement to early widow's or widower's insurance benefits; and §9117, with respect to the demonstration program to assist homeless individuals.

See Vol. II, P.L. 100-204, §724(d), with respect to furnishing information to the United States Commission on Improving the Effectiveness of the United Nations; and §725(b), with respect to the detailing of Government personnel.

See Vol. II, P.L. 100-235, §§5-8, with respect to responsibilities of each Federal agency for computer systems security and privacy.

See Vol. II, P.L. 100-647, §8019, with respect to reports regarding certain disability-related benefits.

See Vol. II, P.L. 100-690, §5301(a)(1)(C) and (d)(1)(B), with respect to benefits of drug traffickers and possessors.

See Vol. II, P.L. 101-239, §10405, with respect to Agent Orange settlement payments excluded from countable income and resources under Federal means-tested programs.

See Vol. II, P.L. 101-508, §5041(2)-(4), with respect to notification of certain individuals eligible to receive retroactive benefits; §5103(e)(2), with respect to application requirements for certain individuals on benefit rolls; §5105(b)(3), with respect to provision of information to local agencies providing child and adult protective services; and §5105(d)(3), with respect to a study to be conducted by the Secretary regarding involvement of the Department of Veterans Affairs.

[2] This table of contents does not appear in the law.

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PURPOSE; APPROPRIATIONS

SEC. 1601. [42 U.S.C. 1381] For the purpose of establishing a national program to provide supplemental security income to individuals who have attained age 65 or are blind or disabled, there are authorized to be appropriated sums sufficient to carry out this title.

BASIC ELIGIBILITY FOR BENEFITS

SEC. 1602. [42 U.S.C. 1381a] Every aged, blind, or disabled individual who is determined under part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be paid benefits by the Secretary of Health and Human Services.

PART A—DETERMINATION OF BENEFITS

ELIGIBILITY FOR AND AMOUNT OF BENEFITS[3]

Definition of Eligible Individual

SEC. 1611. [42 U.S.C. 1382] (a)(1) Each aged, blind, or disabled individual who does not have an eligible spouse and—

(A) whose income, other than income excluded pursuant to section 1612(b), is at a rate of not more than $1,752 (or, if greater, the amount determined under section 1617) for the calendar year 1974 or any calendar year thereafter, and

(B) whose resources, other than resources excluded pursuant to section 1613(a), are not more than (i) in case such individual has a spouse with whom he is living, the applicable amount determined under paragraph (3)(A), or (ii) in case such individual has no spouse with whom he is living, the applicable amount determined under paragraph (3)(B),

shall be an eligible individual for purposes of this title.

(2) Each aged, blind, or disabled individual who has an eligible spouse and—

(A) whose income (together with the income of such spouse), other than income excluded pursuant to section 1612(b), is at a rate of not more than $2,628 (or, if greater, the amount determined under section 1617) for the calendar year 1974, or any calendar year thereafter, and

(B) whose resources (together with the resources of such spouse), other than resources excluded pursuant to section 1613(a), are not more than the applicable amount determined under paragraph (3)(A),

shall be an eligible individual for purposes of this title.

(3)(A) The dollar amount referred to in clause (i) of paragraph (1)(B), and in paragraph (2)(B), shall be $2,250 prior to January 1, 1985, and shall be increased to $2,400 on January 1, 1985, to $2,550 on January 1, 1986, to $2,700 on January 1, 1987, to $2,850 on January 1, 1988, and to $3,000 on January 1, 1989.

(B) The dollar amount referred to in clause (ii) of paragraph (1)(B), shall be $1,500 prior to January 1, 1985, and shall be increased to $1,600 on January 1, 1985, to $1,700 on January 1, 1986, to $1,800 on January 1, 1987, to $1,900 on January 1, 1988, and to $2,000 on January 1, 1989.

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[3] See Vol. II, P.L. 93-66, §211, with respect to supplemental security income benefits for essential persons.

Amounts of Benefits[4]

(b)(1) The benefit under this title for an individual who does not have an eligible spouse shall be payable at the rate of $1,752 (or, if greater, the amount determined under section 1617) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1612(b), of such individual.

(2) The benefit under this title for an individual who has an eligible spouse shall be payable at the rate of $2,628 (or, if greater, the amount determined under section 1617) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1612(b), of such individual and spouse.

Period for Determination of Benefits

(c)(1) An individual's eligibility for a benefit under this title for a month shall be determined on the basis of the individual's (and eligible spouse's, if any) income, resources, and other relevant characteristics in such month, and, except as provided in paragraphs (2), (3), (4), and (5), the amount of such benefit shall be determined for such month on the basis of income and other characteristics in the first or, if the Secretary so determines, second month preceding such month. Eligibility for and the amount of such benefits shall be redetermined at such time or times as may be provided by the Secretary.

(2) The amount of such benefit for the month in which an application for benefits becomes effective (or, if the Secretary so determines, for such month and the following month) and for any month immediately following a month of ineligibility for such benefits (or, if the Secretary so determines, for such month and the following month) shall—

(A) be determined on the basis of the income of the individual and the eligible spouse, if any, of such individual and other relevant circumstances in such month; and

(B) in the case of the month in which an application becomes effective or the first month following a period of ineligibility, if such application becomes effective, or eligibility is restored, after the first day of such month, bear the same ratio to the amount of the benefit which would have been payable to such individual if such application had become effective, or eligibility had been restored, on the first day of such month as the number of days in such month including and following the effective date of such application or restoration of eligibility bears to the total number of days in such month.

(3) For purposes of this subsection, an increase in the benefit amount payable under title II (over the amount payable in the preceding month, or, at the election of the Secretary, the second preceding month) to an individual receiving benefits under this title shall be included in the income used to determine the benefit under this title of such individual for any month which is—

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[4] Changes have been made by publication in the Federal Register: Effective January 1990, the following benefits are payable: Essential person; $2,316; individual, $4,632; individual and spouse, $6,948 (54 FR 45801).

(A) the first month in which the benefit amount payable to such individual under this title is increased pursuant to section 1617, or

(B) at the election of the Secretary, the month immediately following such month.

(4)(A) Notwithstanding paragraph (3), if the Secretary determines that reliable information is currently available with respect to the income and other circumstances of an individual for a month (including information with respect to a class of which such individual is a member and information with respect to scheduled cost-of-living adjustments under other benefit programs), the benefit amount of such individual under this title for such month may be determined on the basis of such information.

(B) The Secretary shall prescribe by regulation the circumstances in which information with respect to an event may be taken into account pursuant to subparagraph (A) in determining benefit amounts under this title.

(5) Notwithstanding paragraphs (1) and (2), any income which is paid to or on behalf of an individual in any month pursuant to (A) a State plan approved under part A of title IV of this Act (relating to aid to families with dependent children), (B) section 472 of this Act (relating to foster care assistance), (C) section 412(e) of the Immigration and Nationality Act (relating to assistance for refugees), (D) section 501(a) of Public Law 96-422 (relating to assistance for Cuban and Haitian entrants), or (E) the Act of November 2, 1921 (42 Stat. 208), as amended (relating to assistance furnished by the Bureau of Indian Affairs), shall be taken into account in determining the amount of the benefit under this title of such individual (and his eligible spouse, if any) only for that month, and shall not be taken into account in determining the amount of the benefit for any other month.

(6) For purposes of this subsection, an application of an individual for benefits under this title shall be effective on the later of—

(A) the date such application is filed, or

(B) the date such individual first becomes eligible for such benefits with respect to such application.

(7) The Secretary may waive the limitations specified in subparagraphs (A) and (B) of subsection (e)(1) on an individual's eligibility and benefit amount for a month (to the extent either such limitation is applicable by reason of such individual's presence throughout such month in a hospital, extended care facility, nursing home, or intermediate care facility) if such waiver would promote the individual's removal from such institution or facility. Upon waiver of such limitations, the Secretary shall apply, to the month preceding the month of removal, or, if the Secretary so determines, the two months preceding the month of removal, the benefit rate that is appropriate to such individual's living arrangement subsequent to his removal from such institution or facility.

Special Limits on Gross Income

(d) The Secretary may prescribe the circumstances under which, consistently with the purposes of this title, the gross income from a trade or business (including farming) will be considered sufficiently large to make an individual ineligible for benefits under this title. For purposes of this subsection, the term "gross income" has the same meaning as when used in chapter 1 of the Internal Revenue Code of 1954[5].

Limitation on Eligibility of Certain Individuals

(e)(1)(A) Except as provided in subparagraphs (B), (C), (D), (E), and (G), no person shall be an eligible individual or eligible spouse for purposes of this title with respect to any month if throughout such month he is an inmate of a public institution.

(B) In any case where an eligible individual or his eligible spouse (if any) is, throughout any month (subject to subparagraph (G)), in a hospital, extended care facility, nursing home, or intermediate care facility receiving payments (with respect to such individual or spouse) under a State plan approved under title XIX, or an eligible individual is a child described in section 1614(f)(2)(B),[6] the benefit under this title for such individual for such month shall be payable (subject to subparagraph (E))—

(i) at a rate not in excess of $360 per year (reduced by the amount of any income not excluded pursuant to section 1612(b)) in the case of an individual who does not have an eligible spouse;

(ii) in the case of an individual who has an eligible spouse, if only one of them is in such a hospital, home or facility throughout such month, at a rate not in excess of the sum of—

(I) the rate of $360 per year (reduced by the amount of any income, not excluded pursuant to section 1612(b), of the one who is in such hospital, home, or facility), and

(II) the applicable rate specified in subsection (b)(1) (reduced by the amount of any income, not excluded pursuant to section 1612(b), of the other); and

(iii) at a rate not in excess of $720 per year (reduced by the amount of any income not excluded pursuant to section 1612(b)) in the case of an individual who has an eligible spouse, if both of them are in such a hospital, home, or facility throughout such month.

For purposes of this subsection, a hospital, extended care facility, nursing home, or intermediate care facility which is a "medical institution or nursing facility" within the meaning of section 1917(c) shall be considered to be receiving payments with respect to an individual under a State plan approved under title XIX during any period of ineligibility of such individual provided for under the State plan pursuant to section 1917(c).

(C) As used in subparagraph (A), the term "public institution" does not include a publicly operated community residence which serves no more than 16 residents.[7]

(D) A person may be an eligible individual or eligible spouse for purposes of this title with respect to any month throughout which he is a resident of a public emergency shelter for the homeless (as defined in regulations which shall be prescribed by the Secretary); except that no person shall be an eligible individual or eligible spouse by reason of this subparagraph more than 6 months in any 9-month period.

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[5] P.L. 83-591.

P.L. 99-514, §2, provides, except when inappropriate, any reference to the Internal Revenue Code of 1954 shall include a reference to the Internal Revenue Code of 1986.

[6] P.L. 101-239, §8010(b), inserted "or an eligible individual is a child described in section 1614(f)(2)(B),", effective on June 1, 1990.

[7] See Vol. II, P.L. 96-598, §4, with respect to the Boundary County Restorium, Bonner's Ferry, Idaho.

(E) Notwithstanding subparagraphs (A) and (B), any individual who—

(i)(I) is an inmate of a public institution, the primary purpose of which is the provision of medical or psychiatric care, throughout any month as described in subparagraph (A), or

(II) is in a hospital, extended care facility, nursing home, or intermediate care facility throughout any month as described in subparagraph (B),

(ii) was eligible under section 1619(a) or (b) for the month preceding such month, and

(iii) under an agreement of the public institution or the hospital, extended care facility, nursing home, or intermediate care facility is permitted to retain any benefit payable by reason of this subparagraph,

may be an eligible individual or eligible spouse for purposes of this title (and entitled to a benefit determined on the basis of the rate applicable under subsection (b)) for the month referred to in subclause (I) or (II) of clause (i) and, if such subclause still applies, for the succeeding month.

(F) An individual who is an eligible individual or an eligible spouse for a month by reason of subparagraph (E) shall not be treated as being eligible under section 1619(a) or (b) for such month for purposes of clause (ii) of such subparagraph.

(G) A person may be an eligible individual or eligible spouse for purposes of this title, and subparagraphs (A) and (B) shall not apply, with respect to any particular month throughout which he or she is an inmate of a public institution the primary purpose of which is the provision of medical or psychiatric care, or which is a hospital, extended care facility, nursing home, or intermediate care facility receiving payments (with respect to such individual or spouse) under a State plan approved under title XIX, if it is determined in accordance with subparagraph (H) that—

(i) such person's stay in that institution or facility (or in that institution or facility and one or more other such institutions or facilities during a continuous period of institutionalization) is likely (as certified by a physician) not to exceed 3 months, and the particular month involved is one of the first 3 months throughout which such person is in such an institution or facility during a continuous period of institutionalization; and

(ii) such person needs to continue to maintain and provide for the expenses of the home or living arrangement to which he or she may return upon leaving the institution or facility.

The benefit of any person under this title (including State supplementation if any) for each month to which this subparagraph applies shall be payable, without interruption of benefit payments and on the date the benefit involved is regularly due, at the rate that was applicable to such person in the month prior to the first month throughout which he or she is in the institution or facility.

(H) The Secretary shall establish procedures for the determinations required by clauses (i) and (ii) of subparagraph (G), and may enter into agreements for making such determinations (or for providing information or assistance in connection with the making of such determinations) with appropriate State and local public and private agencies and organizations. Such procedures and agreements shall include the provision of appropriate assistance to individuals who, because of their physical or mental condition, are limited in their ability to furnish the information needed in connection with the making of such determinations.

(2) No person shall be an eligible individual or eligible spouse for purposes of this title if, after notice to such person by the Secretary that it is likely that such person is eligible for any payments of the type enumerated in section 1612(a)(2)(B), such person fails within 30 days to take all appropriate steps to apply for and (if eligible) obtain any such payments.

(3)(A) No person who is an aged, blind, or disabled individual solely by reason of disability (as determined under section 1614(a)(3)) shall be an eligible individual or eligible spouse for purposes of this title with respect to any month if such individual is medically determined to be a drug addict or an alcoholic unless such individual is undergoing any treatment that may be appropriate for his condition as a drug addict or alcoholic (as the case may be) at an institution or facility approved for purposes of this paragraph by the Secretary (so long as such treatment is available) and demonstrates that he is complying with the terms, conditions, and requirements of such treatment and with requirements imposed by the Secretary under subparagraph (B).

(B) The Secretary shall provide for the monitoring and testing of all individuals who are receiving benefits under this title and who as a condition of such benefits are required to be undergoing treatment and complying with the terms, conditions, and requirements thereof as described in subparagraph (A), in order to assure such compliance and to determine the extent to which the imposition of such requirement is contributing to the achievement of the purposes of this title. The Secretary shall annually submit to the Congress a full and complete report on his activities under this paragraph.

[(4) Stricken.[8]]

(5) Notwithstanding anything to the contrary in the criteria being used by the Secretary in determining when a husband and wife are to be considered two eligible individuals for purposes of this title and when they are to be considered an eligible individual with an eligible spouse, the State agency administering or supervising the administration of a State plan under any other program under this Act may (in the administration of such plan) treat a husband and wife living in the same hospital, home, or facility described in paragraph (1)(B) as though they were an eligible individual with his or her eligible spouse for purposes of this title (rather than two eligible individuals), after they have continuously lived in the same such hospital, home, or facility for 6 months, if treating such husband and wife as two eligible individuals would prevent either of them from receiving benefits or assistance under such plan or reduce the amount thereof.

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[8] P.L. 99-643, §4(d)(1); 100 Stat. 3577.

Suspension of Payments to Individuals Who Are Outside the United States

(f) Notwithstanding any other provision of this title, no individual (other than a child described in section 1614(a)(1)(B)(ii))[9] shall be considered an eligible individual for purposes of this title for any month during all of which such individual is outside the United States (and no person shall be considered the eligible spouse of an individual for purposes of this title with respect to any month during all of which such person is outside the United States). For purposes of the preceding sentence, after an individual has been outside the United States for any period of 30 consecutive days, he shall be treated as remaining outside the United States until he has been in the United States for a period of 30 consecutive days.

Certain Individuals Deemed To Meet Resources Test

(g) In the case of any individual or any individual and his spouse (as the case may be) who—

(1) received aid or assistance for December 1973 under a plan of a State approved under title I, X, XIV, or XVI,

(2) has, since December 31, 1973, continuously resided in the State under the plan of which he or they received such aid or assistance for December 1973, and

(3) has, since December 31, 1973, continuously been (except for periods not in excess of six consecutive months) an eligible individual or eligible spouse with respect to whom supplemental security income benefits are payable,

the resources of such individual or such individual and his spouse (as the case may be) shall be deemed not to exceed the amount specified in sections 1611(a)(1)(B) and 1611(a)(2)(B) during any period that the resources of such individual or such individual and his spouse (as the case may be) does not exceed the maximum amount of resources specified in the State plan, as in effect for October 1972, under which he or they received such aid or assistance for December 1973.

Certain Individuals Deemed To Meet Income Test

(h) In determining eligibility for, and the amount of, benefits payable under this section in the case of any individual or any individual and his spouse (as the case may be) who—

(1) received aid or assistance for December 1973 under a plan of a State approved under title X or XVI,

(2) is blind under the definition of that term in the plan, as in effect for October 1972, under which he or they received such aid or assistance for December 1973,

(3) has, since December 31, 1973, continuously resided in the State under the plan of which he or they received such aid or assistance for December 1973, and

(4) has, since December 31, 1973, continuously been (except for periods not in excess of six consecutive months) an eligible individual or an eligible spouse with respect to whom supplemental security income benefits are payable,

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[9] P.L. 101-239, §8009(a), inserted "(other than a child described in section 1614(a)(1)(B)(ii))", applicable with respect to benefits for months after March 1990.

there shall be disregarded an amount equal to the greater of (A) the maximum amount of any earned or unearned income which could have been disregarded under the State plan, as in effect for October 1972, under which he or they received such aid or assistance for December 1973, and (B) the amount which would be required to be disregarded under section 1612 without application of this subsection.

Application and Review Requirements for Certain Individuals

(i) For application and review requirements affecting the eligibility of certain individuals, see section 1631(j).

INCOME

Meaning of Income

Sec. 1612. [42 U.S.C. 1382a] (a) For purposes of this title, income means both earned income and unearned income; and—

(1) earned income means only—

(A) wages as determined under section 203(f)(5)(C);

(B) net earnings from self-employment, as defined in section 211 (without the application of the second and third sentences following subsection (a)(11), and the last paragraph of subsection (a)), including earnings for services described in paragraphs (4), (5), and (6) of subsection (c);

(C) any refund of Federal income taxes made by reason of section 32 of the Internal Revenue Code of 1954[10] (relating to earned income credit) and any payment made by an employer under section 3507 of such Code[11] (relating to advance payment of earned income credit);[12]

(D) remuneration received for services performed in a sheltered workshop or work activities center; and

(E) any royalty earned by an individual in connection with any publication of the work of the individual, and that portion of any honorarium which is received for services rendered; and[13]

(2) unearned income means all other income, including—

(A) support and maintenance furnished in cash or kind; except that (i) in the case of any individual (and his eligible spouse, if any) living in another person's household and receiving support and maintenance in kind from such person, the dollar amounts otherwise applicable to such individual (and spouse) as specified in subsections (a) and (b) of section 1611 shall be reduced by 33 1/3 percent in lieu of including such support and maintenance in the unearned income of such individual (and spouse) as otherwise required by this subparagraph,[14] (ii) in the case of any individual or his eligible spouse who resides in a nonprofit retirement home or similar nonprofit institution, support and maintenance shall not be included to the extent that it is furnished to such individual or such spouse without such institution receiving payment therefor (unless such institution has expressly undertaken an obligation to furnish full support and maintenance to such individual or spouse without any current or future payment therefor) or payment therefor is made by another nonprofit organization, and (iii) support and maintenance shall not be included and the provisions of clause (i) shall not be applicable in the case of any individual (and his eligible spouse, if any) for the period which begins with the month in which such individual (or such individual and his eligible spouse) began to receive support and maintenance while living in a residential facility (including a private household) maintained by another person and ends with the close of the month in which such individual (or such individual and his eligible spouse) ceases to receive support and maintenance while living in such a residential facility (or, if earlier, with the close of the seventeenth month following the month in which such period began), if, not more than 30 days prior to the date on which such individual (or such individual and his eligible spouse) began to receive support and maintenance while living in such a residential facility, (I) such individual (or such individual and his eligible spouse) were residing in a household maintained by such individual (or by such individual and others) as his or their own home, (II) there occurred within the area in which such household is located (and while such individual, or such individual and his spouse, were residing in the household referred to in subclause (I)) a catastrophe on account of which the President declared a major disaster to exist therein for purposes of the Disaster Relief and Emergency Assistance Act[15], and (III) such individual declares that he (or he and his eligible spouse) ceased to continue living in the household referred to in subclause (II) because of such catastrophe;[16]

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[10] P.L. 83-591.

[11] See P.L. 83-591, §3507, (this volume).

[12] P.L. 101-508, §5034(a)(1)(A), struck out "and".

[13] P.L. 101-508, §5034(a)(1)(B), added subparagraph (E), applicable to benefits for months beginning on or after December 1, 1991.

[14] See Vol. II, P.L. 95-557, §410(c), with respect to individuals receiving services under P.L. 95-557, Title IV.

(B) any payments received as an annuity, pension, retirement, or disability benefit, including veterans' compensation and pensions, workmen's compensation payments, old-age, survivors, and disability insurance benefits, railroad retirement annuities and pensions, and unemployment insurance benefits;

(C) prizes and awards;

(D) payments to the individual occasioned by the death of another person, to the extent that the total of such payments exceeds the amount expended by such individual for purposes of the deceased person's last illness and burial;

(E) support and alimony payments, and (subject to the provisions of subparagraph (D) excluding certain amounts expended for purposes of a last illness and burial) gifts (cash or otherwise) and inheritances; and

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[15] P.L. 93-288.

[16] See Vol. II, 10 U.S.C. 2546, with respect to shelter for the homeless at military installations.

(F) rents, dividends, interest, and royalties not described in paragraph (1)(E)[17].

Exclusions From Income[18]

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[17] P.L. 101-508, §5034(a)(2), inserted "not described in paragraph (1)(E)", applicable to benefits for months beginning on or after December 1, 1991.

[18] See Vol. II, P.L. 79-396, §12(e), with respect to exclusion from income and resources of assistance to children.

See Vol. II, P.L. 81-171, §521(a)(1)(E), with respect to exclusion from income and resources of certain assistance rendered to provide occupant-owned, rental and cooperative housing.

See Vol. II, P.L. 88-525, §8(b), with respect to exclusion from income and resources of the value of food stamps.

See Vol. II, P.L. 89-73, §210(b), with respect to exclusion from income of the costs of any project under that act.

See Vol. II, P.L. 89-329, §479B, with respect to exclusion from income or resources of certain student financial assistance.

See Vol. II, P.L. 89-642, §11(b), with respect to the exclusion from income and resources of the value of assistance to children.

See Vol. II, P.L. 91-646, §216, with respect to exclusion from income of payments under that act.

See Vol. II, P.L. 93-112, §613(c), with respect to the conditional exclusion from income of wages, allowances, transportation reimbursement, and attendant care provided to handicapped individuals under community service employment pilot programs.

See Vol. II, P.L. 93-113, §404(g), with respect to the exclusion from income and resources of payments to volunteers.

See Vol. II, P.L. 93-134, §§7 and 8, with respect to exclusion from income and resources of certain judgment funds to any Indian tribe.

See Vol. II, P.L. 93-288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 94-114, §6, with respect to exclusion from income and resources of property and receipts from submarginal land to certain Indians.

See Vol. II, P.L. 94-375, §2(h), with respect to exclusion from income and resources of the value of assistance paid with respect to a dwelling unit, for purposes of this title of this act. Also see Vol. II:
P.L. 73-479, §§231(a), (b), and (f); 235(a); 236(a) and (j)(6); and 237(a) and (b);
P.L. 75-412, §§8(j) and 9(b);
P.L. 81-171, §521(a)(1)(B), (C), and (E); and
P.L. 89-117, §101.

See Vol. II, P.L. 95-433, §2, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 95-498, §6, with respect to an income and resources exclusion applicable to the Pueblo of Santa Ana Indians, New Mexico.

See Vol. II, P.L. 95-499, §6, with respect to an income and resources exclusion applicable to the Pueblo of Zia Indians, New Mexico.

See Vol. II, P.L. 95-557, §410(b), with respect to exclusion from income of services (but not of wages) provided to a public housing resident or to a resident of a housing project assisted under the "Housing Act of 1959" (Vol. II, P.L. 86-372, §202).

See Vol. II, P.L. 97-35, §2605(f), with respect to exclusion from income and resources of home energy assistance payments or allowances.

See Vol. II, P.L. 98-64, §2(a), with respect to exclusion from income and resources of per capita payments to Indians.

See Vol. II, P.L. 98-432, §5(e), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98-500, §8, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98-602, §106(d), with respect to exclusion from income and resources of certain funds distributed per capita.

See Vol. II, P.L. 99-130, §8, with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99-146, §6(b), with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99-264, §16, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99-346, §6(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99-377, §4(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 100-139, §4(h)(6), with respect to exclusion of benefits as basis for denial of eligibility.

See Vol. II, P.L. 100-383, §§105(f)(2) and 206(d)(2), with respect to exclusion from income and resources of certain payments to certain individuals.

See Vol. II, 31 U.S.C. 3803(c)(2)(C), with respect to benefits not affected by P.L. 100-383.

See Vol. II, P.L. 100-407, §105(c), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100-409, §5, with respect to the effect of this Act on P.L. 92-203 or P.L. 96-487.

See Vol. II, P.L. 100-411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100-581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 101-41, §10(b)-(d), with respect to eligibility for Federal programs and treatment

(b) In determining the income of an individual (and his eligible spouse) there shall be excluded—

(1) subject to limitations (as to amount or otherwise) prescribed by the Secretary, if such individual is a child who is, as determined by the Secretary, a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him for gainful employment, the earned income of such individual;

(2)(A) the first $240 per year (or proportionately smaller amounts for shorter periods) of income (whether earned or unearned) other than income which is paid on the basis of the need of the eligible individual, and

(B) monthly (or other periodic) payments received by any individual, under a program established prior to July 1, 1973 (or any program established prior to such date but subsequently amended so as to conform to State or Federal constitutional standards), if (i) such payments are made by the State of which the individual receiving such payments is a resident, (ii) eligibility of any individual for such payments is not based on need and is based solely on attainment of age 65 or any other age set by the State and residency in such State by such individual, and (iii) on or before September 30, 1985, such individual (I) first becomes an eligible individual or an eligible spouse under this title, and (II) satisfies the twenty-five-year residency requirement of such program as such program was in effect prior to January 1, 1983;

(3)(A) the total unearned income of such individual (and such spouse, if any) in a month which, as determined in accordance with criteria prescribed by the Secretary, is received too infrequently or irregularly to be included, if such income so received does not exceed $20 in such month, and (B) the total earned income of such individual (and such spouse, if any) in a month which, as determined in accordance with such criteria, is received too infrequently or irregularly to be included, if such income so received does not exceed $10 in such month;

(4)(A) if such individual (or such spouse) is blind (and has not attained age 65, or received benefits under this title (or aid under a State plan approved under section 1002 or 1602) for the month before the month in which he attained age 65), (i) the first $780 per year (or proportionately smaller amounts for shorter periods) of earned income not excluded by the preceding paragraphs of this subsection, plus one-half of the remainder thereof, (ii) an amount equal to any expenses reasonably attributable to the earning of any income, and (iii) such additional amounts of other income, where such individual has a plan for achieving self-support approved by the Secretary, as may be necessary for the fulfillment of such plan,

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of funds, assets, and income.

See Vol. II, P.L. 101-42, §3, with respect to the restoration of Federal recognition, rights, and privileges.

See Vol. II, P.L. 101-201, §1, with respect to Agent Orange settlement payments.

See Vol. II, P.L. 101-239, §10405, with respect to Agent Orange settlement payments excluded from countable income and resources under Federal means-tested programs.

See Vol. II, P.L. 101-277, §8(b), with respect to exclusion, from income or resources, of funds held in trust or distributed to Seminole Indians.

(B) if such individual (or such spouse) is disabled but not blind (and has not attained age 65, or received benefits under this title (or aid under a State plan approved under section 1402 or 1602) for the month before the month in which he attained age 65), (i) the first $780 per year (or proportionately smaller amounts for shorter periods) of earned income not excluded by the preceding paragraphs of this subsection, (ii) such additional amounts of earned income of such individual[19], if such individual's disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, as may be necessary to pay the costs (to such individual) of attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary (as determined by the Secretary in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions, except that the amounts to be excluded shall be subject to such reasonable limits as the Secretary may prescribe, (iii) one-half of the amount of earned income not excluded after the application of the preceding provisions of this subparagraph, and (iv) such additional amounts of other income, where such individual has a plan for achieving self-support approved by the Secretary, as may be necessary for the fulfillment of such plan, or

(C) if such individual (or such spouse) has attained age 65 and is not included under subparagraph (A) or (B), the first $780 per year (or proportionately smaller amounts for shorter periods) of earned income not excluded by the preceding paragraphs of this subsection, plus one-half of the remainder thereof;

(5) any amount received from any public agency as a return or refund of taxes paid on real property or on food purchased by such individual (or such spouse);

(6) assistance, furnished to or on behalf of such individual (and spouse), which is based on need and furnished by any State or political subdivision of a State;

(7) any portion of any grant, scholarship, or fellowship received for use in paying the cost of tuition and fees at any educational (including technical or vocational education) institution;

(8) home produce of such individual (or spouse) utilized by the household for its own consumption;

(9) if such individual is a child, one-third of any payment for his support received from an absent parent;

(10) any amounts received for the foster care of a child who is not an eligible individual but who is living in the same home as such individual and was placed in such home by a public or nonprofit private child-placement or child-care agency;

(11) assistance received under the Disaster Relief and Emergency Assistance Act[20] or other assistance provided pursuant to a Federal statute on account of a catastrophe which is declared to be a major disaster by the President;

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[19] P.L. 101-508, §5033(a), struck out "(for purposes of determining the amount of his or her benefits under this title and of determining his or her eligibility for such benefits for consecutive months of eligibility after the initial month of such eligibility)", applicable to benefits payable for calendar months beginning after November 5, 1990.

[20] P.L. 93-288.

(12) interest income received on assistance funds referred to in paragraph (11) within the 9-month period beginning on the date such funds are received (or such longer periods as the Secretary shall by regulations prescribe in cases where good cause is shown by the individual concerned for extending such period);

(13) any support or maintenance assistance furnished to or on behalf of such individual (and spouse if any) which (as determined under regulations of the Secretary by such State agency as the chief executive officer of the State may designate) is based on need for such support or maintenance, including assistance received to assist in meeting the costs of home energy (including both heating and cooling), and which is (A) assistance furnished in kind by a private nonprofit agency, or (B) assistance furnished by a supplier of home heating oil or gas, by an entity providing home energy whose revenues are primarily derived on a rate-of-return basis regulated by a State or Federal governmental entity, or by a municipal utility providing home energy;[21]

(14) assistance paid, with respect to the dwelling unit occupied by such individual (or such individual and spouse), under the United States Housing Act of 1937[22], the National Housing Act[23], section 101 of the Housing and Urban Development Act of 1965[24], title V of the Housing Act of 1949[25], or section 202(h) of the Housing Act of 1959[26]; [27]

(15) the value of any commercial transportation ticket, for travel by such individual (or spouse) among the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, which is received as a gift by such individual (or such spouse) and is not converted to cash;[28]

(16) interest accrued on the value of an agreement entered into by such individual (or such spouse) representing the purchase of a burial space excluded under section 1613(a)(2)(B), and left to accumulate;[29]

(17) any amount received by such individual (or such spouse) from a fund established by a State to aid victims of crime;[30]

(18) relocation assistance provided by a State or local government to such individual (or such spouse), comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 which is subject to the treatment required by section 216 of such Act.[31]

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[21] P.L. 101-239, §8011(a)(1), struck out "and".

[22] P.L. 75-412.

[23] P.L. 73-479.

[24] P.L. 89-117.

[25] P.L. 81-171.

[26] P.L. 86-372.

[27] P.L. 101-239, §8011(a)(2), struck out the period and substituted "; and".
P.L. 101-239, §8013(a)(1), struck out "and".

[28] P.L. 101-239, §8011(a)(3), added paragraph (15), effective March 1, 1990.
P.L. 101-239, §8013(a)(2), struck out the period and substituted "; and".
P.L. 101-508, §5031(a)(1), struck out "and".

[29] P.L. 101-239, §8013(a)(3), added paragraph (16), effective April 1, 1990.
P.L. 101-508, §5031(a)(2), struck out a period and substituted "; and".
P.L. 101-508, §5035(a)(1), struck out "and".

[30] P.L. 101-508, §5031(a)(3), added paragraph (17), applicable to benefits for months beginning on or after May 1, 1991.
P.L. 101-508, §5035(a)(2), struck out a period and substituted a semicolon.

[31] P.L. 101-508, §5035(a)(3), added paragraph (18), applicable to benefits for calendar months beginning in the 3-year period that begins on May 1, 1991.

RESOURCES

Exclusions From Resources[32]

SEC. 1613. [42 U.S.C. 1382b] (a) In determining the resources of an individual (and his eligible spouse, if any) there shall be excluded—

(1) the home (including the land that appertains thereto);

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[32] See Vol. II, P.L. 79-396, §12(e), with respect to exclusion from income and resources of assistance to children.

See Vol. II, P.L. 81-171, §521(a)(1)(E), with respect to exclusion from income and resources of certain assistance rendered to provide occupant-owned, rental and cooperative housing.

See Vol. II, P.L. 88-525, §8(b), with respect to exclusion from income and resources of the value of food stamps.

See Vol. II, P.L. 89-329, §479B, with respect to exclusion from income or resources of certain student financial assistance .

See Vol. II, P.L. 89-642, §11(b), with respect to the exclusion from income and resources of the value of assistance to children.

See Vol. II, P.L. 93-113, §404(g), with respect to exclusion from income and resources of payments to volunteers.

See Vol. II, P.L. 93-134, §§7 and 8, with respect to exclusion from income and resources of certain judgment funds to any Indian tribe.

See Vol. II, P.L. 93-288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 94-114, §6, with respect to exclusion from income and resources of property and receipts from submarginal land to certain Indians.

See Vol. II, P.L. 94-375, §2(h), with respect to exclusion from income and resources of the value of assistance paid with respect to a dwelling unit, for purposes of this title of this act. Also see Vol. II:
P.L. 73-479, §§231(a), (b), and (f); 235(a); 236(a) and (j)(6); and 237(a) and (b);
P.L. 75-412, §§8(j) and 9(b);
P.L. 81-171, §521(a)(1)(B), (C), and (E); and
P.L. 89-117, §101.

See Vol. II, P.L. 95-433, §2, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 95-498, §6, with respect to an income and resources exclusion applicable to the Pueblo of Santa Ana Indians, New Mexico.

See Vol. II, P.L. 95-499, §6, with respect to an income and resources exclusion applicable to the Pueblo of Zia Indians, New Mexico.

See Vol. II, P.L. 97-35, §2605(f), with respect to exclusion from income and resources of home energy assistance payments or allowances.

See Vol. II, P.L. 98-64, §2(a), with respect to exclusion from income and resources of per capita payments to Indians.

See Vol. II, P.L. 98-432, §5(e), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98-500, §8, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 98-602, §106(d), with respect to exclusion from income and resources of certain funds distributed per capita.

See Vol. II, P.L. 99-130, §8, with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99-146, §6(b), with respect to exclusion from income and resources of certain funds.

See Vol. II, P.L. 99-264, §16, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99-346, §6(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 99-377, §4(b), with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 100-139, §4(h)(6), with respect to exclusion of benefits as basis for denial of eligibility.

See Vol. II, P.L. 100-383, §§105(f)(2) and 206(d)(2), with respect to exclusion from income and resources of certain payments to certain individuals.

See Vol. II, 31 U.S.C. 3803(c)(2)(C), with respect to benefits not affected by P.L. 100-383.

See Vol. II, P.L. 100-407, §105(c), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100-409, §5, with respect to the effect of this Act on P.L. 92-203 or P.L. 96-487.

See Vol. II, P.L. 100-411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100-581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 101-41, §10(b)-(d), with respect to eligibility for Federal programs and treatment of funds, assets, and income.

See Vol. II, P.L. 101-42, §3, with respect to the restoration of Federal recognition, rights, and privileges.

See Vol. II, P.L. 101-201, §1, with respect to Agent Orange settlement payments.

See Vol. II, P.L. 101-239, §10405, with respect to Agent Orange settlement payments excluded from countable income and resources under Federal means-tested programs.

See Vol. II, P.L. 101-277, §8(b), with respect to exclusion, from income or resources, of funds held in trust or distributed to Seminole Indians.

(2)(A) household goods, personal effects, and an automobile, to the extent that their total value does not exceed such amount as the Secretary determines to be reasonable; and

(B) the value of any burial space or agreement (including any interest accumulated thereon) representing the purchase of a burial space[33] (subject to such limits as to size or value as the Secretary may by regulation prescribe) held for the purpose of providing a place for the burial of the individual, his spouse, or any other member of his immediate family;

(3) other property which is so essential to the means of self-support of such individual (and such spouse) as to warrant its exclusion, as determined in accordance with and subject to limitations prescribed by the Secretary, except that the Secretary shall not establish a limitation on property (including the tools of a tradesperson and the machinery and livestock of a farmer) that is used in a trade or business or by such individual as an employee;[34]

(4) such resources of an individual who is blind or disabled and who has a plan for achieving self-support approved by the Secretary, as may be necessary for the fulfillment of such plan;

(5) in the case of Natives of Alaska, shares of stock held in a Regional or a Village Corporation, during the period of twenty years in which such stock is inalienable, as provided in section 7(h) and section 8(c) of the Alaska Native Claims Settlement Act[35];

(6) assistance referred to in section 1612(b)(11) for the 9-month period beginning on the date such funds are received (or for such longer period as the Secretary shall by regulations prescribe in cases where good cause is shown by the individual concerned for extending such period); and, for purposes of this paragraph, the term "assistance" includes interest thereon which is excluded from income under section 1612(b)(12);

(7) any amount received from the United States which is attributable to underpayments of benefits due for one or more prior months, under this title or title II, to such individual (or spouse) or to any other person whose income is deemed to be included in such individual's (or spouse's) income for purposes of this title; but the application of this paragraph in the case of any such individual (and eligible spouse if any), with respect to any amount so received from the United States, shall be limited to the first 6 months following the month in which such amount is received (or to the first 9 months following such month with respect to any amount so received during the period beginning October 1, 1987, and ending September 30, 1989), and written notice of this limitation shall be given to the recipient concurrently with the payment of such amount;[36]

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[33] P.L. 101-239, §8013(b), inserted "or agreement (including any interest accumulated thereon) representing the purchase of a burial space", effective April 1, 1990.

[34] P.L. 101-239, §8014(a), amended this paragraph in its entirety, effective May 1, 1990. [For paragraph (3) as it formerly read, see Vol. III, P.L. 101-239.]

[35] P.L. 92-203.

[36] P.L. 101-508, §5031(b)(1), struck out "and".

See Vol. II, P.L. 101-508, §5041(1), with respect to notification of certain individuals eligible to receive retroactive benefits.

(8) the value of assistance referred to in section 1612(b)(14), paid with respect to the dwelling unit occupied by such individual (or such individual and spouse);[37]

(9) for the 9-month period beginning after the month in which received, any amount received by such individual (or such spouse) from a fund established by a State to aid victims of crime, to the extent that such individual (or such spouse) demonstrates that such amount was paid as compensation for expenses incurred or losses suffered as a result of a crime; and[38]

(10) for the 9-month period beginning after the month in which received, relocation assistance provided by a State or local government to such individual (or such spouse), comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 which is subject to the treatment required by section 216 of such Act.[39]

In determining the resources of an individual (or eligible spouse) an insurance policy shall be taken into account only to the extent of its cash surrender value; except that if the total face value of all life insurance policies on any person is $1,500 or less, no part of the value of any such policy shall be taken into account.

Disposition of Resources

(b)(1) The Secretary shall prescribe the period or periods of time within which, and the manner in which, various kinds of property must be disposed of in order not to be included in determining an individual's eligibility for benefits. Any portion of the individual's benefits paid for any such period shall be conditioned upon such disposal; and any benefits so paid shall (at the time of the disposal) be considered overpayments to the extent they would not have been paid had the disposal occurred at the beginning of the period for which such benefits were paid.

(2) Notwithstanding the provisions of paragraph (1), the Secretary shall not require the disposition of any real property for so long as it cannot be sold because (A) it is jointly owned (and its sale would cause undue hardship, due to loss of housing, for the other owner or owners), (B) its sale is barred by a legal impediment, or (C) as determined under regulations issued by the Secretary, the owner's reasonable efforts to sell it have been unsuccessful.

Notification of Medicaid Policy Restricting Eligibility of Institutionalized Individuals for Benefits Based on Disposal of Resources for Less Than Fair Market Value

(c)(1) At the time an individual (and the individual's eligible spouse, if any) applies for benefits under this title, and at the time the eligibility of an individual (and such spouse, if any) for such benefits is redetermined, the Secretary shall—

(A) inform such individual of the provisions of section 1917(c) providing for a period of ineligibility for benefits under title XIX for individuals who make certain dispositions of resources for less than fair market value, and inform such individual that information obtained pursuant to subparagraph (B) will be made available to the State agency administering a State plan under title XIX (as provided in paragraph (2)); and

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[37] P.L. 101-508, §5031(b)(2), struck out a period and substituted "; and".
P.L. 101-508, §5035(b)(1), struck out "and".

[38] P.L. 101-508, §5031(b)(3), added paragraph (9), applicable to benefits for months beginning on or after May 1, 1991.
P.L. 101-508, §5035(b)(2), struck out a period and substituted "; and".

[39] P.L. 101-508, §5035(b)(3), added paragraph (10), applicable to benefits for calendar months beginning in the 3-year period that begins on May 1, 1991.

(B) obtain from such individual information which may be used by the State agency in determining whether or not a period of ineligibility for such benefits would be required by reason of section 1917(c) if such individual (or such spouse, if any) enters a medical institution or nursing facility.

(2) The Secretary shall make the information obtained under paragraph (1)(B) available, on request, to any State agency administering a State plan approved under title XIX.

Funds Set Aside for Burial Expenses

(d)(1) In determining the resources of an individual, there shall be excluded an amount, not in excess of $1,500 each with respect to such individual and his spouse (if any), that is separately identifiable and has been set aside to meet the burial and related expenses of such individual or spouse.

(2) The amount of $1,500, referred to in paragraph (1), with respect to an individual shall be reduced by an amount equal to (A) the total face value of all insurance policies on his life which are owned by him or his spouse and the cash surrender value of which has been excluded in determining the resources of such individual or of such individual and his spouse, and (B) the total of any amounts in an irrevocable trust (or other irrevocable arrangement) available to meet the burial and related expenses of such individual or his spouse.

(3) If the Secretary finds that any part of the amount excluded under paragraph (1) was used for purposes other than those for which it was set aside in cases where the inclusion of any portion of the amount would cause the resources of such individual, or of such individual and spouse, to exceed the limits specified in paragraph (1) or (2) (whichever may be applicable) of section 1611(a), he shall reduce any future benefits payable to the eligible individual (or to such individual and his spouse) by an amount equal to such part.

(4) The Secretary may provide by regulations that whenever an amount set aside to meet burial and related expenses is excluded under paragraph (1) in determining the resources of an individual, any interest earned or accrued on such amount (and left to accumulate), and any appreciation in the value of prepaid burial arrangements for which such amount was set aside, shall also be excluded (to such extent and subject to such conditions or limitations as such regulations may prescribe) in determining the resources (and the income) of such individual.

MEANING OF TERMS

Aged, Blind, or Disabled Individual

SEC. 1614. [42 U.S.C. 1382c] (a)(1) For purposes of this title, the term "aged, blind, or disabled individual" means an individual who—

(A) is 65 years of age or older, is blind (as determined under paragraph (2)), or is disabled (as determined under paragraph (3)), and

(B)(i)[40] is a resident of the United States, and is either (I)[41] a citizen or (II)[42] an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (including any alien who is lawfully present in the United States as a result of the application of the provisions of section 203(a)(7) or section 212(d)(5) of the Immigration and Nationality Act[43]), or[44]

(ii) is a child who is a citizen of the United States, who is living with a parent of the child who is a member of the Armed Forces of the United States assigned to permanent duty ashore outside the United States, the District of Columbia, Puerto Rico, and the territories and possessions of the United States, and who, during the month before the parent reported for such assignment, was receiving benefits under this title.[45]

(2) An individual shall be considered to be blind for purposes of this title if he has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered for purposes of the first sentence of this subsection as having a central visual acuity of 20/200 or less. An individual shall also be considered to be blind for purposes of this title if he is blind as defined under a State plan approved under title X or XVI as in effect for October 1972 and received aid under such plan (on the basis of blindness) for December 1973, so long as he is continuously blind as so defined.

(3)(A) An individual shall be considered to be disabled for purposes of this title if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity).

(B) For purposes of subparagraph (A), an individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

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[40] P.L. 101-239, §8009(b)(1)(B), inserted "(i)".

[41] P.L. 101-239, §8009(b)(1)(A), redesignated clause (i) as subclause (I).

[42] P.L. 101-239, §8009(b)(1)(A), redesignated clause (ii) as subclause (II).

[43] P.L. 82-414.

[44] P.L. 101-239, §8009(b)(1)(C), struck out the period and substituted ", or".

[45] P.L. 101-239, §8009(b)(2), added clause (ii), applicable with respect to benefits for months after March 1990.

(C) For purposes of this paragraph, a physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

(D) The Secretary shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. In determining whether an individual is able to engage in substantial gainful activity by reason of his earnings, where his disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, there shall be excluded from such earnings an amount equal to the cost (to such individual) of any attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary (as determined by the Secretary in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions; except that the amounts to be excluded shall be subject to such reasonable limits as the Secretary may prescribe. Notwithstanding the provisions of subparagraph (B), an individual whose services or earnings meet such criteria shall be found not to be disabled.

(E) Notwithstanding the provisions of subparagraphs (A) through (D), an individual shall also be considered to be disabled for purposes of this title if he is permanently and totally disabled as defined under a State plan approved under title XIV or XVI as in effect for October 1972 and received aid under such plan (on the basis of disability) for December 1973 (and for at least one month prior to July 1973), so long as he is continuously disabled as so defined.

(F) In determining whether an individual's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under this section, the Secretary shall consider the combined effect of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity. If the Secretary does find a medically severe combination of impairments, the combined impact of the impairments shall be considered throughout the disability determination process.

(G) In making determinations with respect to disability under this title, the provisions of sections 221(h), 221(k), and 223(d)(5) shall apply in the same manner as they apply to determinations of disability under title II.

(H) In making any determination under this title with respect to the disability of a child who has not attained the age of 18 years and to whom section 221(h) does not apply, the Secretary shall make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the disability of the child (as determined by the Secretary) evaluates the case of such child.[46]

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[46] P.L. 101-508, §5036(a), added subparagraph (H), applicable to determinations made 6 or more months after November 5, 1990.

(4) A recipient of benefits based on disability under this title may be determined not to be entitled to such benefits on the basis of a finding that the physical or mental impairment on the basis of which such benefits are provided has ceased, does not exist, or is not disabling only if such finding is supported by—

(A) substantial evidence which demonstrates that—

(i) there has been any medical improvement in the individual's impairment or combination of impairments (other than medical improvement which is not related to the individual's ability to work), and

(ii) the individual is now able to engage in substantial gainful activity; or

(B) substantial evidence (except in the case of an individual eligible to receive benefits under section 1619) which—

(i) consists of new medical evidence and a new assessment of the individual's residual functional capacity, and demonstrates that—

(I) although the individual has not improved medically, he or she is nonetheless a beneficiary of advances in medical or vocational therapy or technology (related to the individual's ability to work), and

(II) the individual is now able to engage in substantial gainful activity, or

(ii) demonstrates that—

(I) although the individual has not improved medically, he or she has undergone vocational therapy (related to the individual's ability to work), and

(II) the individual is now able to engage in substantial gainful activity; or

(C) substantial evidence which demonstrates that, as determined on the basis of new or improved diagnostic techniques or evaluations, the individual's impairment or combination of impairments is not as disabling as it was considered to be at the time of the most recent prior decision that he or she was under a disability or continued to be under a disability, and that therefore the individual is able to engage in substantial gainful activity; or

(D) substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) which demonstrates that a prior determination was in error.

Nothing in this paragraph shall be construed to require a determination that an individual receiving benefits based on disability under this title is entitled to such benefits if the prior determination was fraudulently obtained or if the individual is engaged in substantial gainful activity, cannot be located, or fails, without good cause, to cooperate in a review of his or her entitlement or to follow prescribed treatment which would be expected to restore his or her ability to engage in substantial gainful activity. Any determination under this paragraph shall be made on the basis of all the evidence available in the individual's case file, including new evidence concerning the individual's prior or current condition which is presented by the individual or secured by the Secretary. Any determination made under this paragraph shall be made on the basis of the weight of the evidence and on a neutral basis with regard to the individual's condition, without any initial inference as to the presence or absence of disability being drawn from the fact that the individual has previously been determined to be disabled.

Eligible Spouse

(b) For purposes of this title, the term "eligible spouse" means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual, and who, in a month, is living with such aged, blind, or disabled individual on the first day of the month or, in any case in which either spouse files an application for benefits or requests restoration of eligibility under this title during the month, at the time the application or request is filed.[47] If two aged, blind, or disabled individuals are husband and wife as described in the preceding sentence, only one of them may be an "eligible individual" within the meaning of section 1611(a).

Definition of Child

(c) For purposes of this title, the term "child" means an individual who is neither married nor (as determined by the Secretary) the head of a household, and who is (1) under the age of eighteen, or (2) under the age of twenty-two and (as determined by the Secretary) a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him for gainful employment.

Determination of Marital Relationships

(d) In determining whether two individuals are husband and wife for purposes of this title, appropriate State law shall be applied; except that—

(1) if a man and woman have been determined to be husband and wife under section 216(h)(1) for purposes of title II they shall be considered (from and after the date of such determination or the date of their application for benefits under this title, whichever is later) to be husband and wife for purposes of this title, or

(2) if a man and woman are found to be holding themselves out to the community in which they reside as husband and wife, they shall be so considered for purposes of this title notwithstanding any other provision of this section.

United States

(e) For purposes of this title, the term "United States", when used in a geographical sense, means the 50 States and the District of Columbia.

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[47] P.L. 101-239, §8012(a), struck out "For purposes of this title, the term 'eligible spouse' means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual and who has not been living apart from such other aged, blind, or disabled individual for more than six months." and substituted this sentence, effective October 1, 1990.

Income and Resources of Individuals Other Than Eligible Individuals and Eligible Spouses

(f)(1) For purposes of determining eligibility for and the amount of benefits for any individual who is married and whose spouse is living with him in the same household but is not an eligible spouse, such individual's income and resources shall be deemed to include any income and resources of such spouse, whether or not available to such individual, except to the extent determined by the Secretary to be inequitable under the circumstances.

(2)(A)[48] For purposes of determining eligibility for and the amount of benefits for any individual who is a child under age 18, such individual's income and resources shall be deemed to include any income and resources of a parent of such individual (or the spouse of such a parent) who is living in the same household as such individual, whether or not available to such individual, except to the extent determined by the Secretary to be inequitable under the circumstances.

(B) Subparagraph (A) shall not apply in the case of any child who has not attained the age of 18 years who—

(i) is disabled;

(ii) received benefits under this title, pursuant to section 1611(e)(1)(B), while in an institution described in section 1611(e)(1)(B);

(iii) is eligible for medical assistance under a State home care plan approved by the Secretary under the provisions of section 1915(c) relating to waivers, or authorized under section 1902(e)(3); and

(iv) but for this subparagraph, would not be eligible for benefits under this title.[49]

(3) For purposes of determining eligibility for and the amount of benefits for any individual who is an alien, such individual's income and resources shall be deemed to include the income and resources of his sponsor and such sponsor's spouse (if such alien has a sponsor) as provided in section 1621. Any such income deemed to be income of such individual shall be treated as unearned income of such individual.

REHABILITATION SERVICES FOR BLIND AND DISABLED INDIVIDUALS

Sec. 1615. [42 U.S.C. 1382d] (a) In the case of any blind or disabled individual who—

(1) has not attained age 65, and

(2) is receiving benefits (or with respect to whom benefits are paid) under this title,

the Secretary shall make provision for referral of such individual to the appropriate State agency administering the State plan for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973[50], or, in the case of any such individual who has not attained age 16, to the State agency administering the State program under title V, and (except for individuals who have not attained age 16 and except in such other cases as he may determine) for a review not less often than quarterly of such individual's blindness or disability and his need for and utilization of the services made available to him under such plan.

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[48] P.L. 101-239, §8010(a)(1), inserted "(A)".

[49] P.L. 101-239, §8010(a)(2), added subparagraph (B), effective June 1, 1990.

[50] P.L. 93-112.

[(b) Repealed.[51]]

(c) Every individual age 16 or over with respect to whom the Secretary is required to make provision for referral under subsection (a) shall accept such services as are made available to him under the State plan for vocational and rehabilitation services approved under title I of the Rehabilitation Act of 1973; and no such individual shall be an eligible individual or eligible spouse for purposes of this title if he refuses without good cause to accept services for which he is referred under subsection (a).

(d) The Secretary is authorized to reimburse the State agency administering or supervising the administration of a State plan for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973[52] for the costs incurred under such plan in the provision of rehabilitation services to individuals who are referred for such services pursuant to subsection (a)[53] (1) in cases where the furnishing of such services results in the performance by such individuals of substantial gainful activity for a continuous period of nine months, (2) in cases where such individuals receive benefits as a result of section 1631(a)(6) (except that no reimbursement under this subsection shall be made for services furnished to any individual receiving such benefits for any period after the close of such individual's ninth consecutive month of substantial gainful activity or the close of the month with which his or her entitlement to such benefits ceases, whichever first occurs), and (3) in cases where such individuals, without good cause, refuse to continue to accept vocational rehabilitation services or fail to cooperate in such a manner as to preclude their successful rehabilitation. The determination that the vocational rehabilitation services contributed to the successful return of an individual to substantial gainful activity, the determination that an individual, without good cause, refused to continue to accept vocational rehabilitation services or failed to cooperate in such a manner as to preclude successful rehabilitation, and the determination of the amount of costs to be reimbursed under this subsection shall be made by the Commissioner of Social Security in accordance with criteria determined by him in the same manner as under section 222(d)(1).

(e) The Secretary may reimburse the State agency described in subsection (d) for the costs described therein incurred in the provision of rehabilitation services—

(1) for any month for which an individual received—

(A) benefits under section 1611 or 1619(a);

(B) assistance under section 1619(b); or

(C) a federally administered State supplementary payment under section 1616 of this Act or section 212(b) of Public Law 93-66; and

(2) for any month before the 13th consecutive month for which an individual, for a reason other than cessation of disability or blindness, was ineligible for—

(A) benefits under section 1611 or 1619(a);

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[51] P.L. 97-35, §2193(c)(8)(B); 95 Stat. 828.

[52] P.L. 93-112.

[53] As in original. Should have punctuation to signal beginning of a series.

(B) assistance under section 1619(b); or

(C) a federally administered State supplementary payment under section 1616 of this Act or section 212(b) of Public Law 93-66.[54]

OPTIONAL STATE SUPPLEMENTATION

SEC. 1616. [42 U.S.C. 1382e] (a) Any cash payments which are made by a State (or political subdivision thereof) on a regular basis to individuals who are receiving benefits under this title or who would but for their income be eligible to receive benefits under this title, as assistance based on need in supplementation of such benefits (as determined by the Secretary), shall be excluded under section 1612(b)(6) in determining the income of such individuals for purposes of this title and the Secretary and such State may enter into an agreement which satisfies subsection (b) under which the Secretary will, on behalf of such State (or subdivision) make such supplementary payments to all such individuals.

(b) Any agreement between the Secretary and a State entered into under subsection (a) shall provide—

(1) that such payments will be made (subject to subsection (c)) to all individuals residing in such State (or subdivision) who are receiving benefits under this title, and

(2) such other rules with respect to eligibility for or amount of the supplementary payments, and such procedural or other general administrative provisions, as the Secretary finds necessary (subject to subsection (c)) to achieve efficient and effective administration of both the program which he conducts under this title and the optional State supplementation.

At the option of the State (but subject to paragraph (2) of this subsection), the agreement between the Secretary and such State entered into under subsection (a) shall be modified to provide that the Secretary will make supplementary payments, on and after an effective date to be specified in the agreement as so modified, to individuals receiving benefits determined under section 1611(e)(1)(B).

(c)(1) Any State (or political subdivision) making supplementary payments described in subsection (a) may at its option impose as a condition of eligibility for such payments, and include in the State's agreement with the Secretary under such subsection, a residence requirement which excludes individuals who have resided in the State (or political subdivision) for less than a minimum period prior to application for such payments.

(2) Any State (or political subdivision), in determining the eligibility of any individual for supplementary payments described in subsection (a), may disregard amounts of earned and unearned income in addition to other amounts which it is required or permitted to disregard under this section in determining such eligibility, and shall include a provision specifying the amount of any such income that will be disregarded, if any.

(3) Any State (or political subdivision) making supplementary payments described in subsection (a) shall have the option of making such payments to individuals who receive benefits under this title

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[54] P.L. 101-508, §5037(a), added subsection (e), effective November 5, 1990, and applicable to claims for reimbursement pending on or after such date.

under the provisions of section 1619, or who would be eligible to receive such benefits but for their income.[55]

(d) Any State which has entered into an agreement with the Secretary under this section which provides that the Secretary will, on behalf of the State (or political subdivision), make the supplementary payments to individuals who are receiving benefits under this title (or who would but for their income be eligible to receive such benefits), shall, at such times and in such installments as may be agreed upon between the Secretary and such State, pay to the Secretary an amount equal to the expenditures made by the Secretary as such supplementary payments.[56]

(e)(1) Each State shall establish or designate one or more State or local authorities which shall establish, maintain, and insure the enforcement of standards for any category of institutions, foster homes, or group living arrangements in which (as determined by the State) a significant number of recipients of supplemental security income benefits is residing or is likely to reside. Such standards shall be appropriate to the needs of such recipients and the character of the facilities involved, and shall govern such matters as admission policies, safety, sanitation, and protection of civil rights.

(2) Each State shall annually make available for public review a summary of the standards established pursuant to paragraph (1), and shall make available to any interested individual a copy of such standards, along with the procedures available in the State to insure the enforcement of such standards and a list of any waivers of such standards and any violations of such standards which have come to the attention of the authority responsible for their enforcement.

(3) Each State shall certify annually to the Secretary that it is in compliance with the requirements of this subsection.

(4) Payments made under this title with respect to an individual shall be reduced by an amount equal to the amount of any supplementary payment (as described in subsection (a)) or other payment made by a State (or political subdivision thereof) which is made for or on account of any medical or any other type of remedial care provided by an institution of the type described in paragraph (1) to such individual as a resident or an inpatient of such institution if such institution is not approved as meeting the standards described in such paragraph by the appropriate State or local authorities.

COST-OF-LIVING ADJUSTMENTS IN BENEFITS

SEC. 1617. [42 U.S.C. 1382f] (a) Whenever benefit amounts under title II are increased by any percentage effective with any month as a result of a determination made under section 215(i)—

(1) each of the dollar amounts in effect for such month under subsections (a)(1)(A), (a)(2)(A), (b)(1), and (b)(2) of section 1611, and subsection (a)(1)(A) of section 211 of Public Law 93-66, as specified in such subsections or as previously increased under this section, shall be increased by the amount (if any) by which—

(A) the amount which would have been in effect for such month under such subsection but for the rounding of such amount pursuant to paragraph (2), exceeds

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[55] See Vol. II, P.L. 96-265, §201(e), with respect to the maintenance of separate accounts.

[56] See Vol. II, P.L. 92-603, §401(d), with respect to phaseout of the hold harmless provision.

(B) the amount in effect for such month under such subsection; and

(2) the amount obtained under paragraph (1) with respect to each subsection shall be further increased by the same percentage by which benefit amounts under title II are increased for such month, or, if greater (in any case where the increase under title II was determined on the basis of the wage increase percentage rather than the CPI increase percentage), the percentage by which benefit amounts under title II would be increased for such month if the increase had been determined on the basis of the CPI increase percentage, (and rounded, when not a multiple of $12, to the next lower multiple of $12), effective with respect to benefits for months after such month.

(b) The new dollar amounts to be in effect under section 1611 of this title and under section 211 of Public Law 93-66 by reason of subsection (a) of this section shall be published in the Federal Register together with, and at the same time as, the material required by section 215(i)(2)(D) to be published therein by reason of the determination involved.

(c) Effective July 1, 1983—

(1) each of the dollar amounts in effect under subsections (a)(1)(A) and (b)(1) of section 1611, as previously increased under this section, shall be increased by $240 (and the dollar amount in effect under subsection (a)(1)(A) of section 211 of Public Law 93-66, as previously so increased, shall be increased by $120); and

(2) each of the dollar amounts in effect under subsections (a)(2)(A) and (b)(2) of section 1611, as previously increased under this section, shall be increased by $360.

OPERATION OF STATE SUPPLEMENTATION PROGRAMS

Sec. 1618. [42 U.S.C. 1382g] (a) In order for any State which makes supplementary payments of the type described in section 1616(a) (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93-66), on or after June 30, 1977, to be eligible for payments pursuant to title XIX with respect to expenditures for any calendar quarter which begins—

(1) after June 30, 1977, or, if later,

(2) after the calendar quarter in which it first makes such supplementary payments,

such State must have in effect an agreement with the Secretary whereby the State will—

(3) continue to make such supplementary payments, and

(4) maintain such supplementary payments at levels which are not lower than the levels of such payments in effect in December 1976, or, if no such payments were made in that month, the levels for the first subsequent month in which such payments were made.

(b) The Secretary shall not find that a State has failed to meet the requirements imposed by paragraph (4) of subsection (a) with respect to the levels of its supplementary payments for a particular month or months if the State's expenditures for such payments in the twelve-month period (within which such month or months fall) beginning on the effective date of any increase in the level of supplemental security income benefits pursuant to section 1617 are not less than its expenditures for such payments in the preceding twelve-month period.

(c) Any State which satisfies the requirements of this section solely by reason of subsection (b) for a particular month or months in any 12-month period (described in such subsection) ending on or after June 30, 1982, may elect, with respect to any month in any subsequent 12-month period (so described), to apply subsection (a)(4) as though the reference to December 1976 in such subsection were a reference to the month of December which occurred in the 12-month period immediately preceding such subsequent period.

(d) The Secretary shall not find that a State has failed to meet the requirements imposed by paragraph (4) of subsection (a) with respect to the levels of its supplementary payments for any portion of the period July 1, 1980, through June 30, 1981, if the State's expenditures for such payments in that twelve-month period were not less than its expenditures for such payments for the period July 1, 1976, through June 30, 1977 (or, if the State made no supplementary payments in the period July 1, 1976, through June 30, 1977, the expenditures for the first twelve-month period extending from July 1 through June 30 in which the State made such payments).

(e)(1) For any particular month after March 1983, a State which is not treated as meeting the requirements imposed by paragraph (4) of subsection (a) by reason of subsection (b) shall be treated as meeting such requirements if and only if—

(A) the combined level of its supplementary payments (to recipients of the type involved) and the amounts payable (to or on behalf of such recipients) under section 1611(b) of this Act and section 211(a)(1)(A) of Public Law 93-66, for that particular month,

is not less than—

(B) the combined level of its supplementary payments (to recipients of the type involved) and the amounts payable (to or on behalf of such recipients) under section 1611(b) of this Act and section 211(a)(1)(A) of Public Law 93-66, for March 1983, increased by the amount of all cost-of-living adjustments under section 1617 (and any other benefit increases under this title) which have occurred after March 1983 and before that particular month.

(2) In determining the amount of any increase in the combined level involved under paragraph (1)(B) of this subsection, any portion of such amount which would otherwise be attributable to the increase under section 1617(c) shall be deemed instead to be equal to the amount of the cost-of-living adjustment which would have occurred in July 1983 (without regard to the 3-percent limitation contained in section 215(i)(1)(B)) if section 111 of the Social Security Amendments of 1983[57] had not been enacted.

(f) The Secretary shall not find that a State has failed to meet the requirements imposed by subsection (a) with respect to the levels of its supplementary payments for the period January 1, 1984, through December 31, 1985, if in the period January 1, 1986, through December 31, 1986, its supplementary payment levels (other than to recipients of benefits determined under section 1611(e)(1)(B)) are not less than those in effect in December 1976, increased by a percentage equal to the percentage by which payments under section 1611(b) of this Act and section 211(a)(1)(A) of Public Law 93-66 have been increased as a result of all adjustments under section 1617(a) and (c) which have occurred after December 1976 and before February 1986.

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[57] P.L. 98-21.

(g) In order for any State which makes supplementary payments of the type described in section 1616(a) (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93-66) to recipients of benefits determined under section 1611(e)(1)(B), on or after October 1, 1987, to be eligible for payments pursuant to title XIX with respect to any calendar quarter which begins—

(1) after October 1, 1987, or, if later

(2) after the calendar quarter in which it first makes such supplementary payments to recipients of benefits so determined,

such State must have in effect an agreement with the Secretary whereby the State will—

(3) continue to make such supplementary payments to recipients of benefits so determined, and

(4) maintain such supplementary payments to recipients of benefits so determined at levels which assure (with respect to any particular month beginning with the month in which this subsection is first effective) that—

(A) the combined level of such supplementary payments and the amounts payable to or on behalf of such recipients under section 1611(e)(1)(B) for that particular month,

is not less than—

(B) the combined level of such supplementary payments and the amounts payable to or on behalf of such recipients under section 1611(e)(1)(B) for October 1987 (or, if no such supplementary payments were made for that month, the combined level for the first subsequent month for which such payments were made), increased—

(i) in a case to which clause (i) of such section 1611(e)(1)(B) applies or (with respect to the individual or spouse who is in the hospital, home, or facility involved) to which clause (ii) of such section applies, by $5, and

(ii) in a case to which clause (iii) of such section 1611(e)(1)(B) applies, by $10.

BENEFITS FOR INDIVIDUALS WHO PERFORM SUBSTANTIAL GAINFUL ACTIVITY DESPITE SEVERE MEDICAL IMPAIRMENT[58]

SEC. 1619. [42 U.S.C. 1382h]

(a)(1) Except as provided in section 1631(j), any individual who was determined to be an eligible individual (or eligible spouse) by reason of being under a disability and was eligible to receive benefits under section 1611 (or a federally administered State supplementary payment) for a month and whose earnings in a subsequent month exceed the amount designated by the Secretary ordinarily to represent substantial gainful activity shall qualify for a monthly benefit under this subsection for such subsequent month (which shall be in lieu of any benefit under section 1611) equal to an amount determined under section 1611(b)(1) (or, in the case of an individual who has an eligible spouse, under section 1611(b)(2)), and for purposes of title XIX shall be considered to be receiving supplemental security income benefits under this title, for so long as—

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[58] See Vol. II, P.L. 96-265, §201(e), with respect to the maintenance of separate accounts.

(A) such individual continues to have the disabling physical or mental impairment on the basis of which such individual was found to be under a disability; and

(B) the income of such individual, other than income excluded pursuant to section 1612(b), is not equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611 and such individual meets all other non-disability-related requirements for eligibility for benefits under this title.

(2) The Secretary shall make a determination under paragraph (1)(A) with respect to an individual not later than 12 months after the first month for which the individual qualifies for a benefit under this subsection.

(b)(1) Except as provided in section 1631(j), for purposes of title XIX, any individual[59] who was determined to be a blind or disabled individual eligible to receive a benefit under section 1611 or any federally administered State supplementary payment for a month and who in a subsequent month is ineligible for benefits under this title (and for any federally administered State supplementary payments) because of his or her income shall, nevertheless, be considered to be receiving supplemental security income benefits for such subsequent month provided that the Secretary determines under regulations that—

(A) such individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, meets all non-disability-related requirements for eligibility for benefits under this title;

(B) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611(b) (if he were otherwise eligible for such payments);

(C) the termination of eligibility for benefits under title XIX would seriously inhibit his ability to continue his employment; and

(D) such individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under this title (including any federally administered State supplementary payments), benefits under title XIX, and publicly funded attendant care services (including personal care assistance), which would be available to him in the absence of such earnings.

(2)(A) Determinations made under paragraph (1)(D) shall be based on information and data updated no less frequently than annually.

(B) In determining an individual's earnings for purposes of paragraph (1)(D), there shall be excluded from such earnings an amount equal to the sum of any amounts which are or would be excluded under clauses (ii) and (iv) of section 1612(b)(4)(B) (or under clauses (ii) and (iii) of section 1612(b)(4)(A)) in determining his or her income.

(3) In the case of a State that exercises the option under section 1902(f), any individual who—

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[59] P.L. 101-508, §5032(a), struck out "under age 65", applicable to benefits for months beginning on or after May 1, 1991.

(A)(i) qualifies for a benefit under subsection (a), or

(ii) meets the requirements of paragraph (1); and

(B) was eligible for medical assistance under the State plan approved under title XIX in the month immediately preceding the first month in which the individual qualified for a benefit under such subsection or met such requirements,

shall remain eligible for medical assistance under such plan for so long as the individual qualifies for a benefit under such subsection or meets such requirements.

(c) Subsection (a)(2) and section 1631(j)(2)(A) shall not be construed, singly or jointly, to require more than 1 determination during any 12-month period with respect to the continuing disability or blindness of an individual.[60]

(d)[61] The Secretary of Health and Human Services and the Secretary of Education shall jointly develop and disseminate information, and establish training programs for staff personnel, with respect to the potential availability of benefits and services for disabled individuals under the provisions of this section. The Secretary of Health and Human Services shall provide such information to individuals who are applicants for and recipients of benefits based on disability under this title and shall conduct such programs for the staffs of the district offices of the Social Security Administration. The Secretary of Education shall conduct such programs for the staffs of the State Vocational Rehabilitation agencies, and in cooperation with such agencies shall also provide such information to other appropriate individuals and to public and private organizations and agencies which are concerned with rehabilitation and social services or which represent the disabled.

MEDICAL AND SOCIAL SERVICES FOR CERTAIN HANDICAPPED PERSONS

SEC. 1620. [42 U.S.C. 1382i] (a) There are authorized to be appropriated such sums as may be necessary to establish and carry out a 3-year Federal-State pilot program to provide medical and social services for certain handicapped individuals in accordance with this section.

(b)(1) The total sum of $18,000,000 shall be allotted to the States for such program by the Secretary, during the period beginning September 1, 1981, and ending September 30, 1984, as follows:

(A) The total sum of $6,000,000 shall be allotted to the States for the fiscal year ending September 30, 1982 (which for purposes of this section shall include the month of September 1981).

(B) The total sum of $6,000,000, plus any amount remaining available (after the application of paragraph (4)) from the allotment made under subparagraph (A), shall be allotted to the States for the fiscal year ending September 30, 1983.

(C) The total sum of $6,000,000, plus any amount remaining available (after the application of paragraph (4)) from the allotments made under subparagraphs (A) and (B), shall be allotted to the States for the fiscal year ending September 30, 1984.

(2) The allotment to each State from the total sum allotted under paragraph (1) for any fiscal year shall bear the same ratio to such

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[60] P.L. 101-508, §5039(a)(2), added this subsection (c), effective November 5, 1990.

[61] P.L. 101-508, §5039(a)(1), redesignated subsection (c) as subsection (d).

total sum as the number of individuals in such State who are over age 17 and under age 65 and are receiving supplemental security income benefits as disabled individuals in such year (as determined by the Secretary on the basis of the most recent data available) bears to the total number of such individuals in all the States. For purposes of the preceding sentence, the term "supplemental security income benefits" includes payments made pursuant to an agreement under section 1616(a) of this Act or under section 212(b) of Public Law 93-66.

(3) At the beginning of each fiscal year in which the pilot program under this section is in effect, each State that does not intend to use the allotment to which it is entitled for such year (or any allotment which was made to it for a prior fiscal year), or that does not intend to use the full amount of any such allotment, shall certify to the Secretary the amount of such allotment which it does not intend to use, and the State's allotment for the fiscal year (or years) involved shall thereupon be reduced by the amount so certified.

(4) The portion of the total amount available for allotment for any particular fiscal year under paragraph (1) which is not allotted to States for that year by reason of paragraph (3) (plus the amount of any reductions made at the beginning of such year in the allotments of States for prior fiscal years under paragraph (3)) shall be reallocated in such manner as the Secretary may determine to be appropriate to States which need, and will use, additional assistance in providing services to severely handicapped individuals in that particular year under their approved plans. Any amount reallocated to a State under this paragraph for use in a particular fiscal year shall be treated for purposes of this section as increasing such State's allotment for that year by an equivalent amount.

(c) In order to participate in the pilot program and be eligible to receive payments for any period under subsection (d), a State (during such period) must have a plan, approved by the Secretary as meeting the requirements of this section, which provides medical and social services for severely handicapped individuals whose earnings are above the level which ordinarily demonstrates an ability to engage in substantial gainful activity and who are not receiving benefits under section 1611 or 1619 or assistance under a State plan approved under section 1902, and which—

(1) declares the intent of the State to participate in the pilot program;

(2) designates an appropriate State agency to administer or supervise the administration of the program in the State;

(3) describes the criteria to be applied by the State in determining the eligibility of any individual for assistance under the plan and in any event requires a determination by the State agency to the effect that (A) such individual's ability to continue his employment would be significantly inhibited without such assistance and (B) such individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the cash and other benefits that would be available to him under this title and titles XIX and XX in the absence of those earnings;

(4) describes the process by which the eligibility of individuals for such assistance is to be determined (and such process may not involve the performance of functions by any State agency or

entity which is engaged in making determinations of disability for purposes of disability insurance or supplemental security income benefits except when the use of a different agency or entity to perform those functions would not be feasible);

(5) describes the medical and social services to be provided under the plan;

(6) describes the manner in which the medical and social services involved are to be provided and, if they are not to be provided through the State's medical assistance and social services programs under titles XIX and XX (with the Federal payments being made under subsection (d) of this section rather than under those titles), specifies the particular mechanisms and procedures to be used in providing such services; and

(7) contains such other provisions as the Secretary may find to be necessary or appropriate to meet the requirements of this section or otherwise carry out its purpose.

(d)(1) From its allotment under subsection (b) for any fiscal year (and any amounts remaining available from allotments made to it for prior fiscal years), the Secretary shall from time to time pay to each State which has a plan approved under subsection (c) an amount equal to 75 per centum of the total sum expended under such plan (including the cost of administration of such plan) in providing medical and social services to severely handicapped individuals who are eligible for such services under the plan.

(2) The method of computing and making payments under this section shall be as follows:

(A) The Secretary shall, prior to each period for which a payment is to be made to a State, estimate the amount to be paid to the State for such period under the provisions of this section.

(B) From the allotment available therefor, the Secretary shall pay the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this subsection) by which he finds that his estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount which should have been paid to the State for such period under this section.

(e) Within nine months after the date of the enactment of this section[62], the Secretary shall prescribe and publish such regulations as may be necessary or appropriate to carry out the pilot program and otherwise implement this section.

(f) Each State participating in the pilot program under this section shall from time to time report to the Secretary on the operation and results of such program in that State, with particular emphasis upon the work incentive effects of the program. On or before October 1, 1983, the Secretary shall submit to the Congress a report on the program, incorporating the information contained in the State reports along with his findings and recommendations.

ATTRIBUTION OF SPONSOR'S INCOME AND RESOURCES TO ALIENS

SEC. 1621. [42 U.S.C. 1382j] (a) For purposes of determining eligibility for and the amount of benefits under this title for an individual who is an alien, the income and resources of any person who (as a sponsor of such individual's entry into the United States) executed an affidavit of support or similar agreement with respect to such individual, and the income and resources of the sponsor's spouse, shall be deemed to be the income and resources of such individual (in accordance with subsections (b) and (c)) for a period of three years after the individual's entry into the United States. Any such income deemed to be income of such individual shall be treated as unearned income of such individual.

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[62] June 9, 1980 is date of enactment (P.L. 96-265, 94 Stat. 446, 448).

(b)(1) The amount of income of a sponsor (and his spouse) which shall be deemed to be the unearned income of an alien for any year shall be determined as follows:

(A) The total yearly rate of earned and unearned income (as determined under section 1612(a)) of such sponsor and such sponsor's spouse (if such spouse is living with the sponsor) shall be determined for such year.

(B) The amount determined under subparagraph (A) shall be reduced by an amount equal to (i) the maximum amount of the Federal benefit under this title for such year which would be payable to an eligible individual who has no other income and who does not have an eligible spouse (as determined under section 1611(b)(1)), plus (ii) one-half of the amount determined under clause (i) multiplied by the number of individuals who are dependents of such sponsor (or such sponsor's spouse if such spouse is living with the sponsor), other than such alien and such alien's spouse.

(C) The amount of income which shall be deemed to be unearned income of such alien shall be at a yearly rate equal to the amount determined under subparagraph (B). The period for determination of such amount shall be the same as the period for determination of benefits under section 1611(c).

(2) The amount of resources of a sponsor (and his spouse) which shall be deemed to be the resources of an alien for any year shall be determined as follows:

(A) The total amount of the resources (as determined under section 1613) of such sponsor and such sponsor's spouse (if such spouse is living with the sponsor) shall be determined.

(B) The amount determined under subparagraph (A) shall be reduced by an amount equal to (i) the applicable amount determined under section 1611(a)(3)(B) in the case of a sponsor who has no spouse with whom he is living, or (ii) the applicable amount determined under section 1611(a)(3)(A) in the case of a sponsor who has a spouse with whom he is living.

(C) The resources of such sponsor (and spouse) as determined under subparagraphs (A) and (B) shall be deemed to be resources of such alien in addition to any resources of such alien.

(c) In determining the amount of income of an alien during the period of three years after such alien's entry into the United States, the reduction in dollar amounts otherwise required under section 1612(a)(2)(A)(i) shall not be applicable if such alien is living in the household of a person who is a sponsor (or such sponsor's spouse) of such alien, and is receiving support and maintenance in kind from such sponsor (or spouse), nor shall support or maintenance furnished in cash or kind to an alien by such alien's sponsor (to the extent that it reflects income or resources which were taken into account in determining the amount of income and resources to be deemed to the alien under subsection (a) or (b)) be considered to be income of such alien under section 1612(a)(2)(A).

(d)(1) Any individual who is an alien shall, during the period of three years after entry into the United States, in order to be an eligible individual or eligible spouse for purposes of this title, be required to provide to the Secretary such information and documentation with respect to his sponsor as may be necessary in order for the Secretary to make any determination required under this section, and to obtain any cooperation from such sponsor necessary for any such determination. Such alien shall also be required to provide to the Secretary such information and documentation as the Secretary may request and which such alien or his sponsor provided in support of such alien's immigration application.

(2) The Secretary shall enter into agreements with the Secretary of State and the Attorney General whereby any information available to such persons and required in order to make any determination under this section will be provided by such persons to the Secretary, and whereby such persons shall inform any sponsor of an alien, at the time such sponsor executes an affidavit of support or similar agreement, of the requirements imposed by this section.

(e) Any sponsor of an alien, and such alien, shall be jointly and severally liable for an amount equal to any overpayment made to such alien during the period of three years after such alien's entry into the United States, on account of such sponsor's failure to provide correct information under the provisions of this section, except where such sponsor was without fault, or where good cause for such failure existed. Any such overpayment which is not repaid to the Secretary or recovered in accordance with section 1631(b) shall be withheld from any subsequent payment to which such alien or such sponsor is entitled under any provision of this Act.

(f)(1) The provisions of this section shall not apply with respect to any individual who is an "aged, blind, or disabled individual" for purposes of this title by reason of blindness (as determined under section 1614(a)(2)) or disability (as determined under section 1614(a)(3)), from and after the onset of the impairment, if such blindness or disability commenced after the date of such individual's admission into the United States for permanent residence.

(2) The provisions of this section shall not apply with respect to any alien who is—

(A) admitted to the United States as a result of the application, prior to April 1, 1980, of the provisions of section 203(a)(7) of the Immigration and Nationality Act[63];

(B) admitted to the United States as a result of the application, after March 31, 1980, of the provisions of section 207(c)(1) of such Act;

(C) paroled into the United States as a refugee under section 212(d)(5) of such Act; or

(D) granted political asylum by the Attorney General.

PART B—PROCEDURAL AND GENERAL PROVISIONS

PAYMENTS AND PROCEDURES[64]

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[63] P.L. 82-414.

[64] See Vol. II, P.L. 90-321, §913(2), with respect to electronic fund transfers.

Payment of Benefits[65]

SEC. 1631. [42 U.S.C. 1383] (a)(1) Benefits under this title shall be paid at such time or times and in such installments as will best effectuate the purposes of this title, as determined under regulations (and may in any case be paid less frequently than monthly where the amount of the monthly benefit would not exceed $10).

(2)(A)(i) Payments of the benefit of any individual may be made to any such individual or to the eligible spouse (if any) of such individual or partly to each.

(ii) Upon a determination by the Secretary that the interest of such individual would be served thereby, or in the case of any individual or eligible spouse referred to in section 1611(e)(3)(A), such payments shall be made, regardless of the legal competency or incompetency of the individual or eligible spouse, to another individual, or an organization, with respect to whom the requirements of subparagraph (B) have been met (in this paragraph referred to as such individual's "representative payee") for the use and benefit of the individual or eligible spouse.

(iii) If the Secretary or a court of competent jurisdiction determines that the representative payee of an individual or eligible spouse has misused any benefits which have been paid to the representative payee pursuant to clause (ii) or section 205(j)(1), the Secretary shall promptly terminate payment of benefits to the representative payee pursuant to this subparagraph, and provide for payment of benefits to the individual or eligible spouse or to an alternative representative payee of the individual or eligible spouse.[66]

(B)(i) Any determination made under subparagraph (A) for payment of benefits to the representative payee of an individual or eligible spouse shall be made on the basis of—

(I) an investigation by the Secretary of the person to serve as representative payee, which shall be conducted in advance of such payment, and shall, to the extent practicable, include a face-to-face interview with such person; and

(II) adequate evidence that such payment is in the interest of the individual or eligible spouse (as determined by the Secretary in regulations).

(ii) As part of the investigation referred to in clause (i)(I), the Secretary shall—

(I) require the person being investigated to submit documented proof of the identity of such person, unless information establishing such identity was submitted with an application for benefits under title II or this title;

(II) verify the social security account number (or employer identification number) of such person;

(III) determine whether such person has been convicted of a violation of section 208 or 1632; and

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[65] See Vol. II, P.L. 101-508, §5105(b)(2), with respect to a study and report to be made by the Secretary.

[66] P.L. 101-508, §5105(a)(1)(B)(i), amended subparagraph (A) in its entirety, effective July 1, 1991, and applicable only to provisions for payment of benefits under this title to representative payees made on or after July 1, 1991. [For subparagraph (A) as it reads until then, see Vol. III, P.L. 101-508.]

See Vol. II, P.L. 95-608, §201(b), with respect to Indian children.

(IV) determine whether payment of benefits to such person has been terminated pursuant to subparagraph (A)(iii), and whether certification of payment of benefits to such person has been revoked pursuant to section 205(j), by reason of misuse of funds paid as benefits under title II or this title.

(iii) Benefits of an individual may not be paid to any other person pursuant to subparagraph (A)(ii) if—

(I) such person has previously been convicted as described in clause (ii)(III);

(II) except as provided in clause (iv), payment of benefits to such person pursuant to subparagraph (A)(ii) has previously been terminated as described in clause (ii)(IV), or certification of payment of benefits to such person under section 205(j) has previously been revoked as described in section 205(j)(2)(B)(i)(IV); or

(III) except as provided in clause (v), such person is a creditor of such individual who provides such individual with goods or services for consideration.

(iv) The Secretary shall prescribe regulations under which the Secretary may grant an exemption from clause (iii)(II) to any person on a case-by-case basis if such exemption would be in the best interest of the individual or eligible spouse whose benefits under this title would be paid to such person pursuant to subparagraph (A)(ii).

(v) Clause (iii)(III) shall not apply with respect to any person who is a creditor referred to therein if such creditor is—

(I) a relative of such individual if such relative resides in the same household as such individual;

(II) a legal guardian or legal representative of such individual;

(III) a facility that is licensed or certified as a care facility under the law of a State or a political subdivision of a State;

(IV) a person who is an administrator, owner, or employee of a facility referred to in subclause (III) if such individual resides in such facility, and the payment of benefits under this title to such facility or such person is made only after good faith efforts have been made by the local servicing office of the Social Security Administration to locate an alternative representative payee to whom the payment of such benefits would serve the best interests of such individual; or

(V) an individual who is determined by the Secretary, on the basis of written findings and under procedures which the Secretary shall prescribe by regulation, to be acceptable to serve as a representative payee.

(vi) The procedures referred to in clause (v)(V) shall require the individual who will serve as representative payee to establish, to the satisfaction of the Secretary, that—

(I) such individual poses no risk to the beneficiary;

(II) the financial relationship of such individual to the beneficiary poses no substantial conflict of interest; and

(III) no other more suitable representative payee can be found.

(vii) Subject to clause (viii), if the Secretary makes a determination described in subparagraph (A)(ii) with respect to any individual's benefit and determines that direct payment of the benefit to the individual would cause substantial harm to the individual, the Secretary may defer (in the case of initial entitlement) or suspend (in the case of existing entitlement) direct payment of such benefit to the individual, until such time as the selection of a representative payee is made pursuant to this subparagraph.

(viii)(I) Except as provided in subclause (II), any deferral or suspension of direct payment of a benefit pursuant to clause (vii) shall be for a period of not more than 1 month.

(II) Subclause (I) shall not apply in any case in which the individual or eligible spouse is, as of the date of the Secretary's determination, legally incompetent, under the age 15 years, or a drug addict or alcoholic referred to in section 1611(e)(3)(A).

(ix) Payment pursuant to this subparagraph of any benefits which are deferred or suspended pending the selection of a representative payee shall be made to the individual, or to the representative payee upon such selection, as a single sum or over such period of time as the Secretary determines is in the best interests of the individual entitled to such benefits.

(x) Any individual who is dissatisfied with a determination by the Secretary to pay such individual's benefits to a representative payee under this title, or with the designation of a particular person to serve as representative payee, shall be entitled to a hearing by the Secretary, and to judicial review of the Secretary's final decision, to the same extent as is provided in subsection (c).

(xi) In advance of the first payment of an individual's benefit to a representative payee under subparagraph (A)(ii), the Secretary shall provide written notice of the Secretary's initial determination to make any such payment. Such notice shall be provided to such individual, except that, if such individual—

(I) is under the age of 15,

(II) is an unemancipated minor under the age of 18, or

(III) is legally incompetent,

then such notice shall be provided solely to the legal guardian or legal representative of such individual.

(xii) Any notice described in clause (xi) shall be clearly written in language that is easily understandable to the reader, shall identify the person to be designated as such individual's representative payee, and shall explain to the reader the right under clause (x) of such individual or of such individual's legal guardian or legal representative—

(I) to appeal a determination that a representative payee is necessary for such individual,

(II) to appeal the designation of a particular person to serve as the representative payee of such individual, and

(III) to review the evidence upon which such designation is based and submit additional evidence.[67]

(C)(i) In any case where payment is made under this title to[68] representative payee of an individual or spouse[69], the Secretary shall establish a system of accountability monitoring whereby such person shall report not less often than annually with respect to the use of such payments. The Secretary shall establish and implement statistically valid procedures for reviewing such reports in order to identify instances in which such persons are not properly using such payments.

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[67] P.L. 101-508, §5105(a)(2)(A)(ii), amended subparagraph (B) in its entirety, effective July 1, 1991, and applicable only to provisions for payment of benefits under this title to representative payees made on or after July 1, 1991. [For subparagraph (B) as it formerly read, see Vol. III, P.L. 101-508.]

See Vol. II, P.L. 101-508, §5105(a)(2)(B), with respect to a study and report on the feasibility of obtaining ready access to certain criminal fraud records.

[68] As in original. Probably should read "to a".

[69] P.L. 101-508, §5105(a)(1)(B)(ii)(I), struck out "a person other than the individual or spouse entitled to such payment" and substituted "representative payee of an individual or spouse", effective July 1,1991, and applicable only to provisions for payment of benefits under this title to representative payees made on or after July 1, 1991.

(ii) Clause (i) shall not apply in any case where the representative payee[70] is a parent or spouse of the individual entitled to such payment who lives in the same household as such individual. The Secretary shall require such parent or spouse to verify on a periodic basis that such parent or spouse continues to live in the same household as such individual.

(iii) Clause (i) shall not apply in any case where the representative payee[71] is a State institution. In such cases, the Secretary shall establish a system of accountability monitoring for institutions in each State.

(iv) Clause (i) shall not apply in any case where the individual entitled to such payment is a resident of a Federal institution and the representative payee[72] is the institution.

(v) Notwithstanding clauses (i), (ii), (iii), and (iv), the Secretary may require a report at any time from any representative payee[73], if the Secretary has reason to believe that the representative payee[74] is misusing such payments.

(D)(i) A qualified organization may collect from an individual a monthly fee for expenses (including overhead) incurred by such organization in providing services performed as such individual's representative payee pursuant to subparagraph (A)(ii) if the fee does not exceed the lesser of—

(I) 10 percent of the monthly benefit involved, or

(II) $25.00 per month.

Any agreement providing for a fee in excess of the amount permitted under this clause shall be void and shall be treated as misuse by the organization of such individual's benefits.

(ii) For purposes of this subparagraph, the term "qualified organization" means any community-based nonprofit social service agency which—

(I) is bonded or licensed in each State in which the agency serves as a representative payee;

(II) in accordance with any applicable regulations of the Secretary—

(aa) regularly provides services as a representative payee pursuant to subparagraph (A)(ii) or section 205(j)(4) concurrently to 5 or more individuals;

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[70] P.L. 101-508, §5105(a)(1)(B)(ii)(II), struck out "other person to whom such payment is made" and substituted "representative payee", effective July 1, 1991, and applicable only to provisions for payment of benefits under this title to representative payees made on or after July 1, 1991.

[71] P.L. 101-508, §5105(a)(1)(B)(ii)(II), struck out "other person to whom such payment is made" and substituted "representative payee", effective July 1, 1991, and applicable only to provisions for payment of benefits under this title to representative payees made on or after July 1, 1991.

[72] P.L. 101-508, §5105(a)(1)(B)(ii)(II), struck out "other person to whom such payment is made" and substituted "representative payee", effective July 1, 1991, and applicable only to provisions for payment of benefits under this title to representative payees made on or after July 1, 1991.

[73] P.L. 101-508, §5105(a)(1)(B)(ii)(III)(aa), struck out "person receiving payments on behalf of another" and substituted "representative payee", effective July 1, 1991, and applicable only to provisions for payment of benefits under this title to representative payees made on or after July 1, 1991.

[74] P.L. 101-508, §5105(a)(1)(B)(ii)(III)(bb), struck out "person receiving such payments" and substituted "representative payee", effective July 1, 1991, and applicable only to provisions for payment of benefits under this title to representative payees made on or after July 1, 1991.

(bb) demonstrates to the satisfaction of the Secretary that such agency is not otherwise a creditor of any such individual; and

(cc) was in existence on October 1, 1988.

The Secretary shall prescribe regulations under which the Secretary may grant an exception from subclause (II)(bb) for any individual on a case-by-case basis if such exception is in the best interests of such individual.

(iii) Any qualified organization which knowingly charges or collects, directly or indirectly, any fee in excess of the maximum fee prescribed under clause (i) or makes any agreement, directly or indirectly, to charge or collect any fee in excess of such maximum fee, shall be fined in accordance with title 18, United States Code, or imprisoned not more than 6 months, or both.

(iv) This subparagraph shall cease to be effective on July 1, 1994.[75]

(E) RESTITUTION.—In cases where the negligent failure of the Secretary to investigate or monitor a representative payee results in misuse of benefits by the representative payee, the Secretary shall make payment to the beneficiary or the beneficiary's representative payee of an amount equal to such misused benefits. The Secretary shall make a good faith effort to obtain restitution from the terminated representative payee.[76]

(F) The Secretary shall include as a part of the annual report required under section 704 information with respect to the implementation of the preceding provisions of this paragraph, including—

(i) the number of cases in which the representative payee was changed;

(ii) the number of cases discovered where there has been a misuse of funds;

(iii) how any such cases were dealt with by the Secretary;

(iv) the final disposition of such cases (including any criminal penalties imposed); and

(v) such other information as the Secretary determines to be appropriate.[77]

(3) The Secretary may by regulation establish ranges of incomes within which a single amount of benefits under this title shall apply.

(4) The Secretary—

(A) may make to any individual initially applying for benefits under this title who is presumptively eligible for such benefits and who is faced with financial emergency a cash advance against such benefits, including any federally-administered State supplementary payments, in an amount not exceeding the monthly amount that would be payable to an eligible individual with no other income for the first month of such presumptive eligibility; and

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[75] P.L. 101-508, §5105(a)(3)(A)(ii)(III)(sic), added subparagraph (D), effective July 1, 1991, and the Secretary shall prescribe initial regulations necessary to carry out such amendment not later than such date.

See Vol. II, P.L. 101-508, §5105(a)(3)(B)(i) and (a)(4), with respect to studies and reports regarding organizations which serve as representative payees and the feasibility of screening individuals with criminal records.

[76] P.L. 101-508, §5105(c)(2), added this subparagraph (E), effective November 5, 1990.

[77] P.L. 101-508, §5105(a)(3)(A)(ii)(I), redesignated subparagraph (D) as subparagraph (E).

P.L. 101-508, §5105(c)(2), redesignated such subparagraph (E) as subparagraph (F).

P.L. 101-508, §5105(d)(1)(B), amended subparagraph (E) (as redesignated by §5105(c)(2)) in its entirety, applicable to annual reports issued for years after 1991.

For annual reports issued for years before 1992, subparagraph (F) reads as follows:

"(F) The Secretary shall make an initial report to each House of the Congress on the implementation of subparagraphs (B) and (C) within 270 days after the date of the enactment of this subparagraph*. The Secretary shall include in the annual report required under section 704, information with respect to the implementation of subparagraphs (B) and (C), including the same factors as are required to be included in the Secretary's report under section 205(j)(4)(B).".

*This subparagraph was enacted October 9, 1984. [P.L. 98-460, §16(b); 98 Stat. 1810]

(B) may pay benefits under this title to an individual applying for such benefits on the basis of disability or blindness for a period not exceeding 6[78] months prior to the determination of such individual's disability or blindness, if such individual is presumptively disabled or blind and is determined to be otherwise eligible for such benefits, and any benefits so paid prior to such determination shall in no event be considered overpayments for purposes of subsection (b) solely because such individual is determined not to be disabled or blind.

(5) Payment of the benefit of any individual who is an aged, blind, or disabled individual solely by reason of blindness (as determined under section 1614(a)(2)) or disability (as determined under section 1614(a)(3)), and who ceases to be blind or to be under such disability, shall continue (so long as such individual is otherwise eligible) through the second month following the month in which such blindness or disability ceases.

(6) Notwithstanding any other provision of this title, payment of the benefit of any individual who is an aged, blind, or disabled individual solely by reason of blindness (as determined under section 1614(a)(2)) or disability (as determined under section 1614(a)(3)) shall not be terminated or suspended because the blindness or other physical or mental impairment, on which the individual's eligibility for such benefit is based, has or may have ceased, if—

(A) such individual is participating in a program of vocational rehabilitation services approved by the Secretary, and[79],

(B) the Secretary[80] determines that the completion of such program, or its continuation for a specified period of time, will increase the likelihood that such individual may (following his participation in such program) be permanently removed from the blindness and disability benefit rolls.

(7)(A) In any case where—

(i) an individual is a recipient of benefits based on disability or blindness under this title,

(ii) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and as a consequence such individual is determined not to be entitled to such benefits, and

(iii) a timely request for review or for a hearing is pending with respect to the determination that he is not so entitled,

such individual may elect (in such manner and form and within such time as the Secretary shall by regulations prescribe) to have the payment of such benefits continued for an additional period beginning with the first month beginning after the date of the enactment of this paragraph[81] for which (under such determination) such benefits are no longer otherwise payable, and ending with the earlier of (I) the month preceding the month in which a decision is made after such a hearing, or (II) the month preceding the month in which no such request for review or a hearing is pending.

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[78] P.L. 101-508, §5038(a), struck out "3" and substituted "6", applicable to benefits for months beginning on or after May 1, 1991.

[79] P.L. 101-508, §5113(b)(1), amended subparagraph (A) in its entirety, effective for benefits payable for months after October 1991, and applicable to individuals whose blindness or disability has or may have ceased after October 1991. [For subparagraph (A) as it reads until then, see Vol. III, P.L. 101-508.]

[80] P.L. 101-508, §5113(b)(2), struck out "Commissioner of Social Security" and substituted "Secretary", effective for benefits payable for months after October 1991 and applicable to individuals whose blindness or disability has or may have ceased after October 1991.

(B)(i) If an individual elects to have the payment of his benefits continued for an additional period under subparagraph (A), and the final decision of the Secretary affirms the determination that he is not entitled to such benefits, any benefits paid under this title pursuant to such election (for months in such additional period) shall be considered overpayments for all purposes of this title, except as otherwise provided in clause (ii).

(ii) If the Secretary determines that the individual's appeal of his termination of benefits was made in good faith, all of the benefits paid pursuant to such individual's election under subparagraph (A) shall be subject to waiver consideration under the provisions of subsection (b)(1).

(C) The provisions of subparagraphs (A) and (B) shall apply with respect to determinations (that individuals are not entitled to benefits) which are made on or after the date of the enactment of this paragraph[82], or prior to such date but only on the basis of a timely request for review or for a hearing.

(8)(A) In any case in which an administrative law judge has determined after a hearing as provided in subsection (c) that an individual is entitled to benefits based on disability or blindness under this title and the Secretary has not issued his final decision in such case within 110 days after the date of the administrative law judge's determination, such benefits shall be currently paid for the months during the period beginning with the month in which such 110-day period expires and ending with the month in which such final decision is issued.

(B) For purposes of subparagraph (A), in determining whether the 110-day period referred to in subparagraph (A) has elapsed, any period of time for which the action or inaction of such individual or such individual's representative without good cause results in the delay in the issuance of the Secretary's final decision shall not be taken into account to the extent that such period of time exceeds 20 calendar days.

(C) Any benefits currently paid under this title pursuant to this paragraph (for the months described in subparagraph (A)) shall not be considered overpayments for any purposes of this title, unless payment of such benefits was fraudulently obtained.[83]

(9) Benefits under this title shall not be denied to any individual solely by reason of the refusal of the individual to accept an amount offered as compensation for a crime of which the individual was a victim.[84]

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[81] This paragraph was enacted October 9, 1984. [P.L. 98-460, §7(b); 98 Stat. 1083]

[82] This paragraph was enacted October 9, 1984. [P.L. 98-460, §7(b); 98 Stat. 1083]

[83] P.L. 100-647, §8001(b), added paragraph (8), applicable to determinations by administrative law judges of entitlement to benefits made after May 9, 1989.

[84] P.L. 101-508, §5031(c), added paragraph (9), applicable to benefits for months beginning on or after May 1, 1991.

Overpayments and Underpayments

(b)(1)(A) Whenever the Secretary finds that more or less than the correct amount of benefits has been paid with respect to any individual, proper adjustment or recovery shall, subject to the succeeding provisions of this subsection, be made by appropriate adjustments in future payments to such individual or by recovery from such individual or his eligible spouse (or from the estate of either) or by payment to such individual or his eligible spouse, or, if such individual is deceased, by payment—

(i) to any surviving spouse of such individual, whether or not the individual's eligible spouse, if (within the meaning of the first sentence of section 202(i)) such surviving husband or wife was living in the same household with the individual at the time of his death or within the 6 months immediately preceding the month of such death, or

(ii) if such individual was a disabled or blind child who was living with his parent or parents at the time of his death or within the 6 months immediately preceding the month of such death, to such parent or parents.

(B) The Secretary (i) shall make such provision as he finds appropriate in the case of payment of more than the correct amount of benefits with respect to an individual with a view to avoiding penalizing such individual or his eligible spouse who was without fault in connection with the overpayment, if adjustment or recovery on account of such overpayment in such case would defeat the purposes of this title, or be against equity and good conscience, or (because of the small amount involved) impede efficient or effective administration of this title, and (ii) shall in any event make the adjustment or recovery (in the case of payment of more than the correct amount of benefits), in the case of an individual or eligible spouse receiving benefit payments under this title (including supplementary payments of the type described in section 1616(a) and payments pursuant to an agreement entered into under section 212(a) of Public Law 93-66), in amounts which in the aggregate do not exceed (for any month) the lesser of (I) the amount of his or their benefit under this title for that month or (II) an amount equal to 10 percent of his or their income for that month (including such benefit but excluding any other income excluded pursuant to section 1612(b)), unless fraud, willful misrepresentation, or concealment of material information was involved on the part of the individual or spouse in connection with the overpayment, or unless the individual requests that such adjustment or recovery be made at a higher or lower rate and the Secretary determines that adjustment or recovery at such rate is justified and appropriate. The availability (in the case of an individual who has been paid more than the correct amount of benefits) of procedures for adjustment or recovery at a limited rate under clause (ii) of the preceding sentence shall not, in and of itself, prevent or restrict the provision (in such case) of more substantial relief under clause (i) of such sentence.

(2) Notwithstanding any other provision of this section, when any payment of more than the correct amount is made to or on behalf of an individual who has died, and such payment—

(A) is made by direct deposit to a financial institution;

(B) is credited by the financial institution to a joint account of the deceased individual and another person; and

(C) such other person is the surviving spouse of the deceased individual, and was eligible for a payment under this title (including any State supplementation payment paid by the Secretary) as an eligible spouse (or as either member of an eligible couple) for the month in which the deceased individual died,

the amount of such payment in excess of the correct amount shall be treated as a payment of more than the correct amount to such other person.

(3) In any case in which advance payments for a taxable year made by all employers to an individual under section 3507 of the Internal Revenue Code of 1954[85] (relating to advance payment of earned income credit) exceed the amount of such individual's earned income credit allowable under section 32 of such Code[86] for such year, so that such individual is liable under section 32(g) of such Code for a tax equal to such excess, the Secretary shall provide for an appropriate adjustment of such individual's benefit amount under this title so as to provide payment to such individual of an amount equal to the amount of such benefits lost by such individual on account of such excess advance payments.

(4) If any overpayment with respect to an individual (or an individual and his or her spouse) is attributable solely to the ownership or possession by such individual (and spouse if any) of resources having a value which exceeds the applicable dollar figure specified in paragraph (1)(B) or (2)(B) of section 1611(a) by $50 or less, such individual (and spouse if any) shall be deemed for purposes of the second sentence of paragraph (1) to have been without fault in connection with the overpayment, and no adjustment or recovery shall be made under the first sentence of such paragraph, unless the Secretary finds that the failure of such individual (and spouse if any) to report such value correctly and in a timely manner was knowing and willful.

(5) For payments for which adjustments are made by reason of a retroactive payment of benefits under title II, see section 1127.

Hearings and Review

(c)(1)(A)[87] The Secretary is directed to make findings of fact, and decisions as to the rights of any individual applying for payment under this title. Any such decision by the Secretary which involves a determination of disability and which is in whole or in part unfavorable to such individual shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the Secretary's determination and the reason or reasons upon which it is based. The Secretary shall provide reasonable notice and opportunity for a hearing to any individual who is or claims to be an eligible individual or eligible spouse and is in disagreement with any determination under this title with respect to eligibility of such individual for benefits, or the amount of such individual's benefits, if such individual requests a hearing on the matter in disagreement within sixty days after notice of such determination is received, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing affirm, modify, or reverse his findings of fact and such decision. The Secretary is further authorized, on his own motion, to hold such hearings and to conduct such investigations and other proceedings as he may deem necessary or proper for the administration of this title. In the course of any hearing, investigation, or other proceeding, he may administer oaths and affirmations, examine witnesses, and receive evidence. Evidence may be received at any hearing before the Secretary even though inadmissible under the rules of evidence applicable to court procedure. The Secretary shall specifically take into account any physical, mental, educational, or linguistic limitation of such individual (including any lack of facility with the English language) in determining, with respect to the eligibility of such individual for benefits under this title, whether such individual acted in good faith or was at fault, and in determining fraud, deception, or intent.[88]

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[85] P.L. 83-591, §3507 (this volume).

[86] P.L. 83-591.

[87] P.L. 101-508, §5107(a)(2)(A), redesignated paragraph (1) as subparagraph (A).

(B)(i) A failure to timely request review of an initial adverse determination with respect to an application for any payment under this title or an adverse determination on reconsideration of such an initial determination shall not serve as a basis for denial of a subsequent application for any payment under this title if the applicant demonstrates that the applicant, or any other individual referred to in paragraph (1), failed to so request such a review acting in good faith reliance upon incorrect, incomplete, or misleading information, relating to the consequences of reapplying for payments in lieu of seeking review of an adverse determination, provided by any officer or employee of the Social Security Administration or any State agency acting under section 221.

(ii) In any notice of an adverse determination with respect to which a review may be requested under paragraph (1), the Secretary shall describe in clear and specific language the effect on possible eligibility to receive payments under this title of choosing to reapply in lieu of requesting review of the determination.[89]

(2) Determination on the basis of such hearing, except to the extent that the matter in disagreement involves a disability (within the meaning of section 1614(a)(3)), shall be made within ninety days after the individual requests the hearing as provided in paragraph (1).

(3) The final determination of the Secretary after a hearing under paragraph (1) shall be subject to judicial review as provided in section 205(g) to the same extent as the Secretary's final determinations under section 205.

Procedures; Prohibitions of Assignments; Representation of Claimants

(d)(1) The provisions of section 207 and subsections (a), (d), and (e) of section 205 shall apply with respect to this part to the same extent as they apply in the case of title II.

(2)(A) The provisions of section 206(a) (other than paragraph (4) thereof) shall apply to this part to the same extent as they apply in the case of title II, except that paragraph (2) thereof shall be applied—

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[88] P.L. 101-239, §10305(e), added this sentence, applicable with respect to determinations made on or after July 1, 1990.

[89] P.L. 101-508, §5107(a)(2)(B), added subparagraph (B), applicable to adverse determinations made on or after July 1, 1991.

(i) by substituting "section 1127(a) or 1631(g)" for "section 1127(a)"; and

(ii) by substituting "section 1631(a)(7)(A) or the requirements of due process of law" for "subsection (g) or (h) of section 223".[90]

(B) The Secretary shall notify each claimant in writing, together with the notice to such claimant of an adverse determination, of the options for obtaining attorneys to represent individuals in presenting their cases before the Secretary. Such notification shall also advise the claimant of the availability to qualifying claimants of legal services organizations which provide legal services free of charge.[91]

Applications and Furnishing of Information[92]

(e)(1)(A) The Secretary shall, subject to subparagraph (B) and subsection (j), prescribe such requirements with respect to the filing of applications, the suspension or termination of assistance, the furnishing of other data and material, and the reporting of events and changes in circumstances, as may be necessary for the effective and efficient administration of this title.

(B) The requirements prescribed by the Secretary pursuant to subparagraph (A) shall require that eligibility for benefits under this title will not be determined solely on the basis of declarations by the applicant concerning eligibility factors or other relevant facts, and that relevant information will be verified from independent or collateral sources and additional information obtained as necessary in order to assure that such benefits are only provided to eligible individuals (or eligible spouses) and that the amounts of such benefits are correct. For this purpose and for purposes of federally administered supplementary payments of the type described in section 1616(a) of this Act (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93-66), the Secretary shall, as may be necessary, request and utilize information available pursuant to section 6103(l)(7) of the Internal Revenue Code of 1954[93], and any information which may be available from State systems under section 1137 of this Act, and shall comply with the requirements applicable to States (with respect to information available pursuant to section 6103(l)(7)(B) of such Code) under subsections (a)(6) and (c) of such section 1137.

(2) In case of the failure by any individual to submit a report of events and changes in circumstances relevant to eligibility for or amount of benefits under this title as required by the Secretary under paragraph (1), or delay by any individual in submitting a report as so required, the Secretary (in addition to taking any other action he may consider appropriate under paragraph (1)) shall reduce any benefits which may subsequently become payable to such individual under this title by—

(A) $25 in the case of the first such failure or delay,

(B) $50 in the case of the second such failure or delay, and

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[90] P.L. 101-508, §5106(a)(2), amended paragraph (2)(A) in its entirety, applicable to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after April 1, 1991. [For paragraph (2)(A) as it reads until then, see Vol. III, P.L. 101-508.]

[91] P.L. 101-239, §10307(b)(2)(B), added subparagraph (B), applicable with respect to adverse determinations made on or after January 1, 1991.

[92] See Vol. II, P.L. 88-525, §11(i), with respect to inquiry into the need for food stamps.
See Vol. II, P.L. 95-630, §§1101-1121, with respect to an individual's right to financial privacy.

[93] P.L. 83-591.

(C) $100 in the case of the third or a subsequent such failure or delay,

except where the individual was without fault or good cause for such failure or delay existed.

(3) The Secretary shall provide a method of making payments under this title to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(5)[94] In any case in which it is determined to the satisfaction of the Secretary that an individual failed as of any date to apply for benefits under this title by reason of misinformation provided to such individual by any officer or employee of the Social Security Administration relating to such individual's eligibility for benefits under this title, such individual shall be deemed to have applied for such benefits on the later of—

(A) the date on which such misinformation was provided to such individual, or

(B) the date on which such individual met all requirements for entitlement to such benefits (other than application therefor).[95]

(6) In any case in which an individual visits a field office of the Social Security Administration and represents during the visit to an officer or employee of the Social Security Administration in the office that the individual's visit is occasioned by—

(1) the receipt of a notice from the Social Security Administration indicating a time limit for response by the individual, or

(2) the theft, loss, or nonreceipt of a benefit payment under this title,

the Secretary shall ensure that the individual is granted a face-to-face interview at the office with an officer or employee of the Social Security Administration before the close of business on the day of the visit.[96]

Furnishing of Information by Other Agencies[97]

(f) The head of any Federal agency shall provide such information as the Secretary needs for purposes of determining eligibility for or amount of benefits, or verifying other information with respect thereto.

Reimbursement to States for Interim Assistance Payments

(g)(1) Notwithstanding subsection (d)(1) and subsection (b) as it relates to the payment of less than the correct amount of benefits, the Secretary may, upon written authorization by an individual, withhold benefits due with respect to that individual and may pay to a State (or a political subdivision thereof if agreed to by the Secretary and the State) from the benefits withheld an amount sufficient to reimburse the State (or political subdivision) for interim assistance furnished on behalf of the individual by the State (or political subdivision).

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[94] As in original; no paragraph (4) enacted.

[95] P.L. 101-239, §10302(b)(1), added this paragraph, applicable with respect to misinformation furnished on or after December 19, 1989, and to benefits for months after December 1989.

[96] P.L. 101-239, §10303(b), added this paragraph, applicable to visits to field offices of the Social Security Administration on or after January 1, 1990.

[97] See Vol. II, P.L. 95-630, §§1101-1121, with respect to an individual's right to financial privacy.

(2) For purposes of this subsection, the term "benefits" with respect to any individual means supplemental security income benefits under this title, and any State supplementary payments under section 1616 or under section 212 of Public Law 93-66 which the Secretary makes on behalf of a State (or political subdivision thereof), that the Secretary has determined to be due with respect to the individual at the time the Secretary makes the first payment of benefits with respect to the period described in clause (A) or (B) of paragraph (3). A cash advance made pursuant to subsection (a)(4)(A) shall not be considered as the first payment of benefits for purposes of the preceding sentence.

(3) For purposes of this subsection, the term "interim assistance" with respect to any individual means assistance financed from State or local funds and furnished for meeting basic needs (A) during the period, beginning with the month in which the individual filed an application for benefits (as defined in paragraph (2)), for which he was eligible for such benefits, or (B) during the period beginning with the first month for which the individual's benefits (as defined in paragraph (2)) have been terminated or suspended if the individual was subsequently found to have been eligible for such benefits.

(4) In order for a State to receive reimbursement under the provisions of paragraph (1), the State shall have in effect an agreement with the Secretary which shall provide—

(A) that if the Secretary makes payment to the State (or a political subdivision of the State as provided for under the agreement) in reimbursement for interim assistance (as defined in paragraph (3)) for any individual in an amount greater than the reimbursable amount authorized by paragraph (1), the State (or political subdivision) shall pay to the individual the balance of such payment in excess of the reimbursable amount as expeditiously as possible, but in any event within ten working days or a shorter period specified in the agreement; and

(B) that the State will comply with such other rules as the Secretary finds necessary to achieve efficient and effective administration of this subsection and to carry out the purposes of the program established by this title, including protection of hearing rights for any individual aggrieved by action taken by the State (or political subdivision) pursuant to this subsection.

(5) The provisions of subsection (c) shall not be applicable to any disagreement concerning payment by the Secretary to a State pursuant to the preceding provisions of this subsection nor the amount retained by the State (or political subdivision).

Payment of Certain Travel Expenses[98]

(h) The Secretary shall pay travel expenses, either on an actual cost or commuted basis, to individuals for travel incident to medical examinations requested by the Secretary in connection with disability determinations under this title, and to parties, their representatives, and all reasonably necessary witnesses for travel within the United States (as defined in section 1614(e)) to attend reconsideration interviews and proceedings before administrative law judges with respect to any determination under this title. The amount available under the preceding sentence for payment for air travel by any person shall not exceed the coach fare for air travel between the points involved unless the use of first-class accommodations is required (as determined under regulations of the Secretary) because of such person's health condition or the unavailability of alternative accommodations; and the amount available for payment for other travel by any person shall not exceed the cost of travel (between the points involved) by the most economical and expeditious means of transportation appropriate to such person's health condition, as specified in such regulations. The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount allowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding.[99]

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[98] See Vol. II, P.L. 101-166 and P.L. 101-517, with respect to limitation on administrative expenses.

Payment to States With Respect to Certain Unnegotiated Checks

(i)(1) The Secretary of the Treasury shall, on a monthly basis, notify the Secretary of all benefit checks issued under this title which include amounts representing State supplementary payments as described in paragraph (2) and which have not been presented for payment within one hundred and eighty days after the day on which they were issued.

(2) The Secretary shall from time to time determine the amount representing the total of the State supplementary payments made pursuant to agreements under section 1616(a) of this Act and under section 212(b) of Public Law 93-66 which is included in all such benefit checks not presented for payment within one hundred and eighty days after the day on which they were issued, and shall pay each State (or credit each State with) an amount equal to that State's share of all such amount. Amounts not paid to the States shall be returned to the appropriation from which they were originally paid.

(3) The Secretary, upon notice from the Secretary of the Treasury under paragraph (1), shall notify any State having an agreement described in paragraph (2) of all such benefit checks issued under that State's agreement which were not presented for payment within one hundred and eighty days after the day on which they were issued.

(4) The Secretary shall, to the maximum extent feasible, investigate the whereabouts and eligibility of the individuals whose benefit checks were not presented for payment within one hundred and eighty days after the day on which they were issued.

Application and Review Requirements for Certain Individuals

(j)(1) Notwithstanding any provision of section 1611 or 1619, any individual who—

(A) was an eligible individual (or eligible spouse) under section 1611 or was eligible for benefits under or pursuant to section 1619, and

(B) who, after such eligibility, is ineligible for benefits under or pursuant to both such sections for a period of 12 consecutive months, may not thereafter become eligible for benefits under or pursuant to either such section until the individual has reapplied for benefits under section 1611 and been determined to be eligible for benefits under such section.

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[99] P.L. 101-508, §5106(c), added this sentence, applicable to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after April 1, 1991.

(2)(A) Notwithstanding any provision of section 1611 or section 1619 (other than subsection (c) thereof)[100], any individual who was eligible for benefits pursuant to section 1619(b), and who—

(i)(I) on the basis of the same impairment on which his or her eligibility under such section 1619(b) was based becomes eligible for benefits under section 1611 or 1619(a) for a month that follows a period during which the individual was ineligible for benefits under sections 1611 and 1619(a), and

(II) has earned income (other than income excluded pursuant to section 1612(b)) for any month in the 12-month period preceding such month that is equal to or in excess of the amount that would cause him or her to be ineligible for payments under section 1611(b) for that month (if he or she were otherwise eligible for such payments); or

(ii)(I) on the basis of the same impairment on which his or her eligibility under such section 1619(b) was based becomes eligible under section 1619(b) for a month that follows a period during which the individual was ineligible under section 1611 and section 1619, and

(II) has earned income (other than income excluded pursuant to section 1612(b)) for such month or for any month in the 12-month period preceding such month that is equal to or in excess of the amount that would cause him or her to be ineligible for payments under section 1611(b) for that month (if he or she were otherwise eligible for such payments),

shall, upon becoming eligible (as described in clause (i)(I) or (ii)(I)), be subject to a prompt review of the type described in section 1614(a)(4).

(B) If the Secretary determines pursuant to a review required by subparagraph (A) that the impairment upon which the eligibility of an individual is based has ceased, does not exist, or is not disabling, such individual may not thereafter become eligible for a benefit under or pursuant to section 1611 or section 1619 until the individual has reapplied for benefits under section 1611 and been determined to be eligible for benefits under such section.

Notifications to Applicants and Recipients

(k) The Secretary shall notify an individual receiving benefits under section 1611 on the basis of disability or blindness of his or her potential eligibility for benefits under or pursuant to section 1619—

(1) at the time of the initial award of benefits to the individual under section 1611 (if the individual has attained the age of 18 at the time of such initial award), and

(2) at the earliest time after an initial award of benefits to an individual under section 1611 that the individual's earned income for a month (other than income excluded pursuant to section 1612(b)) is $200 or more, and periodically thereafter so long as such individual has earned income (other than income so excluded) of $200 or more per month.

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[100] P.L. 101-508, §5039(b), inserted "(other than subsection (c) thereof)", effective November 5, 1990.

Special Notice to Blind Individuals with Respect to Hearings and Other Official Actions

(l)(1) In any case where an individual who is applying for or receiving benefits under this title on the basis of blindness is entitled (under subsection (c) or otherwise) to receive notice from the Secretary of any decision or determination made or other action taken or proposed to be taken with respect to his or her rights under this title, such individual shall at his or her election be entitled either (A) to receive a supplementary notice of such decision, determination, or action, by telephone, within 5 working days after the initial notice is mailed, (B) to receive the initial notice in the form of a certified letter, or (C) to receive notification by some alternative procedure established by the Secretary and agreed to by the individual.[101]

(2) The election under paragraph (1) may be made at any time; but an opportunity to make such an election shall in any event be given (A) to every individual who is an applicant for benefits under this title on the basis of blindness, at the time of his or her application, and (B) to every individual who is a recipient of such benefits on the basis of blindness, at the time of each redetermination of his or her eligibility. Such an election, once made by an individual, shall apply with respect to all notices of decisions, determinations, and actions which such individual may thereafter be entitled to receive under this title until such time as it is revoked or changed.

Pre-release Procedures for Institutionalized Persons

(m) The Secretary shall develop a system under which an individual can apply for supplemental security income benefits under this title prior to the discharge or release of the individual from a public institution.[102]

CONCURRENT SSI AND FOOD STAMP APPLICATIONS BY INSTITUTIONALIZED INDIVIDUALS[103]

(n) The Secretary and the Secretary of Agriculture shall develop a procedure under which an individual who applies for supplemental security income benefits under this subsection shall also be permitted to apply at the same time for participation in the food stamp program authorized under the Food Stamp Act of 1977[104] (7 U.S.C. 2011 et seq.).

NOTICE REQUIREMENTS[105]

(n) The Secretary shall take such actions as are necessary to ensure that any notice to one or more individuals issued pursuant to this title by the Secretary or by a State agency—

(1) is written in simple and clear language, and

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[101] See Vol. II, P.L. 100-203, §9111(a)(2), with respect to making an election.

[102] P.L. 101-508, §5040(1), struck out "The Secretary and the Secretary of Agriculture shall develop a procedure under which an individual who applies for supplemental security income benefits under this title shall also be permitted to apply for participation in the food stamp program by executing a single application.", effective November 5, 1990.

[103] P.L. 101-508, §5040(2), added this subsection (n), effective November 5, 1990.

[104] P.L. 88-525.

[105] P.L. 101-508, §5109(a)(2), added this subsection (n), applicable to notices issued on or after July 1, 1991.

(2) includes the address and telephone number of the local office of the Social Security Administration which serves the recipient.

In the case of any such notice which is not generated by a local servicing office, the requirements of paragraph (2) shall be treated as satisfied if such notice includes the address of the local office of the Social Security Administration which services the recipient of the notice and a telephone number through which such office can be reached.

PENALTIES FOR FRAUD[106]

SEC. 1632. [42 U.S.C. 1383a] (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit, or (B) the initial or continued right to any such benefit of any other individual in whose behalf he has applied for or is receiving such benefit, conceals or fails to disclose such event with an intent fraudulently to secure such benefit either in a greater amount or quantity than is due or when no such benefit is authorized, or

(4) having made application to receive any such benefit for the use and benefit of another and having received it, knowingly and willfully converts such benefit or any part thereof to a use other than for the use and benefit of such other person,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $1,000 or imprisoned for not more than one year, or both.

(b)(1) Any person or other entity who is convicted of a violation of any of the provisions of paragraphs (1) through (4) of subsection (a), if such violation is committed by such person or entity in his role as, or in applying to become, a payee under section 1631(a)(2) on behalf of another individual (other than such person's eligible spouse), in lieu of the penalty set forth in subsection (a)—

(A) upon his first such conviction, shall be guilty of a misdemeanor and shall be fined not more than $5,000 or imprisoned for not more than one year, or both; and

(B) upon his second or any subsequent such conviction, shall be guilty of a felony and shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) In any case in which the court determines that a violation described in paragraph (1) includes a willful misuse of funds by such person or entity, the court may also require that full or partial restitution of such funds be made to the individual for whom such person or entity was the certified payee.

(3) Any person or entity convicted of a felony under this section or under section 208 may not be certified as a payee under section 1631(a)(2).

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[106] See Vol. II, 18 U.S.C. 1028 and 1738, with respect to penalties relating to use of identification documents.

ADMINISTRATION

SEC. 1633. [42 U.S.C. 1383b] (a) Subject to subsection (b), the Secretary may make such administrative and other arrangements (including arrangements for the determination of blindness and disability under section 1614(a)(2) and (3) in the same manner and subject to the same conditions as provided with respect to disability determinations under section 221) as may be necessary or appropriate to carry out his functions under this title.

(b) In determining, for purposes of this title, whether an individual is blind, there shall be an examination of such individual by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select.

(c) In any case in which the Secretary initiates a review under this title, similar to the continuing disability reviews authorized for purposes of title II under section 221(i), the Secretary shall notify the individual whose case is to be reviewed in the same manner as required under section 221(i)(4).

DETERMINATIONS OF MEDICAID ELIGIBILITY[107]

SEC. 1634. [42 U.S.C. 1383c] (a) The Secretary may enter into an agreement with any State which wishes to do so under which he will determine eligibility for medical assistance in the case of aged, blind, or disabled individuals under such State's plan approved under title XIX. Any such agreement shall provide for payments by the State, for use by the Secretary in carrying out the agreement, of an amount equal to one-half of the cost of carrying out the agreement, but in computing such cost with respect to individuals eligible for benefits under this title, the Secretary shall include only those costs which are additional to the costs incurred in carrying out this title.

(b)(1) An eligible disabled widow or widower (described in paragraph (2)) who is entitled to a widow's or widower's insurance benefit based on a disability for any month under section 202(e) or (f) but is not eligible for benefits under this title in that month, and who applies for the protection of this subsection under paragraph (3), shall be deemed for purposes of title XIX to be an individual with respect to whom benefits under this title are paid in that month if he or she—

(A) has been continuously entitled to such widow's or widower's insurance benefits from the first month for which the increase described in paragraph (2)(C) was reflected in such benefits through the month involved, and

(B) would be eligible for benefits under this title in the month involved if the amount of the increase described in paragraph (2)(C) in his or her widow's or widower's insurance benefits, and any subsequent cost-of-living adjustments in such benefits under section 215(i), were disregarded.

(2) For purposes of paragraph (1), the term "eligible disabled widow or widower" means an individual who—

(A) was entitled to a monthly insurance benefit under title II for December 1983,

(B) was entitled to a widow's or widower's insurance benefit based on a disability under section 202(e) or (f) for January 1984 and with respect to whom a benefit under this title was paid in that month, and

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[107] See Vol. II, P.L. 94-566, §503, with respect to preservation of medicaid eligibility.

(C) because of the increase in the amount of his or her widow's or widower's insurance benefits which resulted from the amendments made by section 134 of the Social Security Amendments of 1983 (Public Law 98- 21) (eliminating the additional reduction factor for disabled widows and widowers under age 60), was ineligible for benefits under this title in the first month in which such increase was paid to him or her (and in which a retroactive payment of such increase for prior months was not made).

(3) This subsection shall only apply to an individual who files a written application for protection under this subsection, in such manner and form as the Secretary may prescribe, no later than July 1, 1988.

(4) For purposes of this subsection, the term "benefits under this title" includes payments of the type described in section 1616(a) or of the type described in section 212(a) of Public Law 93-66.[108]

(c) If any individual who has attained the age of 18 and is receiving benefits under this title on the basis of blindness or a disability which began before he or she attained the age of 22—

(1) becomes entitled, on or after the effective date of this subsection, to child's insurance benefits which are payable under section 202(d) on the basis of such disability or to an increase in the amount of the child's insurance benefits which are so payable, and

(2) ceases to be eligible for benefits under this title because of such child's insurance benefits or because of the increase in such child's insurance benefits,

such individual shall be treated for purposes of title XIX as receiving benefits under this title so long as he or she would be eligible for benefits under this title in the absence of such child's insurance benefits or such increase.[109]

(d)(1) This subsection applies with respect to any person who[110]—

(A)[111] applies for and obtains benefits under subsection (e) or (f) of section 202 (or under any other subsection of section 202 if such person is also eligible for benefits under such subsection (e) or (f)) being then not entitled[112] to hospital insurance benefits under part A of title XVIII, and

(B)[113] is determined to be ineligible (by reason of the receipt of such benefits under section 202) for supplemental security income benefits under this title or for State supplementary payments of the type described in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93-66).[114]

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[108] See Vol. II, P.L. 99-272, §12202(b), with respect to identification of beneficiaries who might qualify for medical assistance under §1634(b).

[109] See Vol. II, P.L. 99-643, §6(b), with respect to State determinations.

[110] P.L. 101-508, §5103(c)(1)(B), struck out "If any person" and substituted "(1) This subsection applies with respect to any person who", applicable to medical assistance provided after December 1990.

[111] P.L. 101-508, §5103(c)(1)(A), redesignated paragraph (1) as subparagraph (A).

[112] P.L. 101-508, §5103(c)(1)(C), struck out "as required by section 1611(e)(2), being then at least 60 years of age but not entitled" and substituted "being then not entitled", applicable to medical assistance provided after December 1990.

[113] P.L. 101-508, §5103(c)(1)(A), redesignated paragraph (2) as subparagraph (B).

[114] P.L. 101-508, §5103(c)(1)(D), struck out a comma and substituted "(or payments of the type described in section 212(a) of Public Law 93-66).", applicable to medical assistance provided after December 1990.

(2) For purposes of title XIX, each person with respect to whom this subsection applies—

(A) shall be deemed to be a recipient of supplemental security income benefits under this title if such person received such a benefit for the month before the month in which such person began to receive a benefit described in paragraph (1)(A), and

(B) shall be deemed to be a recipient of State supplementary payments of the type referred to in section 1616(a) of this Act (or payments of the type described in section 212(a) of Public Law 93-66) if such person received such a payment for the month before the month in which such person began to receive a benefit described in paragraph (1)(A),

for so long as such person (i) would be eligible for such supplemental security income benefits, or such State supplementary payments (or payments of the type described in section 212(a) of Public Law 93-66), in the absence of benefits described in paragraph (1)(A), and (ii) is not entitled to hospital insurance benefits under part A of title XVIII.[115]

SEC. 1635. [42 U.S.C. 1383d] OUTREACH PROGRAM FOR CHILDREN.[116]

(a)ESTABLISHMENT.—The Secretary shall establish and conduct an ongoing program of outreach to children who are potentially eligible for benefits under this title by reason of disability or blindness.

(b)REQUIREMENTS.—Under this program, the Secretary shall—

(1) aim outreach efforts at populations for whom such efforts would be most effective; and

(2) work in cooperation with other Federal, State, and private agencies, and nonprofit organizations, which serve blind or disabled individuals and have knowledge of potential recipients of supplemental security income benefits, and with agencies and organizations (including school systems and public and private social service agencies) which focus on the needs of children.

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[115] P.L. 101-508, §5103(c)(1)(E), struck out "such person shall nevertheless be deemed to be a recipient of supplemental security income benefits under this title for purposes of title XIX, so long as he or she (A) would be eligible for such supplemental security income benefits, or such State supplementary payments, in the absence of such benefits under section 202, and (B) is not entitled to hospital insurance benefits under part A of title XVIII." and substituted paragraph (2), applicable to medical assistance provided after December 1990.

[116] P.L. 101-239, §8008(a), added §1635, effective March 19, 1990.

TITLE XVII—GRANTS FOR PLANNING COMPREHENSIVE ACTION TO COMBAT MENTAL RETARDATION[1]

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AUTHORIZATION OF APPROPRIATIONS

SECTION 1701. [42 U.S.C. 1391] For the purpose of assisting the States (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa) to plan for and take other steps leading to comprehensive State and community action to combat mental retardation, there is authorized to be appropriated the sum of $2,200,000. There are also authorized to be appropriated, for assisting such States in initiating the implementation and carrying out of planning and other steps to combat mental retardation, $2,750,000 for the fiscal year ending June 30, 1966, and $2,750,000 for the fiscal year ending June 30, 1967.

GRANTS TO STATES

SEC. 1702. [42 U.S.C. 1392] The sums appropriated pursuant to the first sentence of section 1701 shall be available for grants to States by the Secretary during the fiscal year ending June 30, 1964, and the succeeding fiscal year; and the sums appropriated pursuant to the second sentence of such section for the fiscal year ending June 30, 1966, shall be available for such grants during such year and the next two fiscal years, and sums appropriated pursuant thereto for the fiscal year ending June 30, 1967, shall be available for such grants during such year and the succeeding fiscal year. Any such grant to a State, which shall not exceed 75 per centum of the cost of the planning and related activities involved, may be used by it to determine what action is needed to combat mental retardation in the State and the resources available for this purpose, to develop public awareness of the mental retardation problem and of the need for combating it, to coordinate State and local activities relating to the various aspects of mental retardation and its prevention, treatment, or amelioration, and to plan other activities leading to comprehensive State and community action to combat mental retardation.

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[1] Title XVII of the Social Security Act is administered by the Rehabilitation Services Administration, Office of Special Education and Rehabilitative Services, Department of Education.

Title XVII appears in the United States Code as §§1391-1394, subchapter XVII, chapter 7, Title 42.

No regulations have been promulgated for Title XVII.

Title XVII was added to the Social Security Act by P.L. 88-156, "Maternal and Child Health and Mental Retardation Planning Amendments of 1963", §5 (77 Stat. 273, 275), effective October 24, 1963; however, it now is inactive.

[2] This table of contents does not appear in the law.

APPLICATIONS

Sec. 1703. [42 U.S.C. 1393] In order to be eligible for a grant under section 1702, a State must submit an application therefor which—

(1) designates or establishes a single State agency, which may be an interdepartmental agency, as the sole agency for carrying out the purposes of this title;

(2) indicates the manner in which provision will be made to assure full consideration of all aspects of services essential to planning for comprehensive State and community action to combat mental retardation, including services in the fields of education, employment, rehabilitation, welfare, health, and the law, and services provided through community programs for and institutions for the mentally retarded;

(3) sets forth its plans for expenditure of such grant, which plans provide reasonable assurance of carrying out the purposes of this title;

(4) provides for submission of a final report of the activities of the State agency in carrying out the purposes of this title, and for submission of such other reports, in such form and containing such information, as the Secretary[3] may from time to time find necessary for carrying out the purposes of this title and for keeping such records and affording such access thereto as he may find necessary to assure the correctness and verification of such reports; and

(5) provides for such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement of and accounting for funds paid to the State under this title.

PAYMENTS

Sec. 1704. [42 U.S.C. 1394] Payment of grants under this title may be made (after necessary adjustment on account of previously made underpayments or overpayments) in advance or by way of reimbursement, and in such installments and on such conditions, as the Secretary may determine.

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[3] P.L. 88-156, §6, provides that the term "Secretary" means the Secretary of Health, Education, and Welfare [now Secretary of Health and Human Services].

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED[1]

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[1] Title XVIII of the Social Security Act is administered by the Health Care Financing Administration, Department of Health and Human Services (formerly Department of Health, Education, and Welfare).

Title XVIII appears in the United States Code as §§1395-1395ccc, subchapter XVIII, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services relating to Title XVIII are contained in chapter IV, Title 42, and in subtitle A, Title 45, Code of Federal Regulations.

See Vol. II, P.L. 78-410, §304(d)(1) and (4), with respect to study of cost of diseases and other adverse effects which are environmentally related; and §353(i)(3) and (n), with respect to clinical laboratories.

See Vol. II, P.L. 88-352, §601, for prohibition against discrimination in Federally assisted programs.

See Vol. II, P.L. 89-73, §§203 and 422(c), with respect to consultation.

See Vol. II, P.L. 93-288, §312(d), with respect to exclusion from income and resources of certain Federal major disaster and emergency assistance.

See Vol. II, P.L. 94-437, §706, with respect to a limitation on the use of funds appropriated to the Indian Health Service; and §713(b)(2)(A), with respect to medicare and medicaid reimbursements.

See Vol. II, P.L. 95-250, §201(19), with respect to trust fund contributions, and §204(b)(4), with respect to Title XVIII ineligibility.

See Vol. II, P.L. 95-521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 96-265, §505 [as amended by P.L. 101-239], with respect to experiments, demonstration projects, and required reports to Congress.

See Vol. II, P.L. 97- 248, §119, with respect to private sector review initiative and restriction against recovery from beneficiaries; §122(i), with respect to hospice demonstration projects and a report to Congress.

See Vol. II, P.L. 98-21, §603, with respect to a variety of studies and reports to Congress.

See Vol. II, P.L. 98-369, §2312(d), with respect to a study of methods of reimbursement and a report to Congress; and §2355, with respect to waivers for social health maintenance organizations; and §2326(a) [as amended by P.L. 101-239, §6215(a)], with respect to contracts for medicare claims processing.

See Vol. II, P.L. 99-177, §257(b)(3) and (c)(3), with respect to the calculation of the baseline.

See Vol. II, P.L. 99-272, §9202(c)-(h), with respect to additional provisions concerning payments to hospitals for direct costs of medical education; §9204, with respect to a moratorium on laboratory payment demonstration projects; §9220, with respect to extension, terms, conditions, and period of approval of the extension of On Lok waiver; §9221, with respect to the continuation of the "Access: Medicare" demonstration projects; and §9314, with respect to a demonstration program designed to reduce disability and dependency through the provision of preventive health services to medicare beneficiaries; and §9215 [as amended by P.L. 101-239, §6135], with respect to the extension of certain medicare health services demonstration projects.

See Vol. II, P.L. 99-319, §105, with respect to systems requirements.

See Vol. II, P.L. 99- 509, §9302(d)(4) with respect to a rural secondary specialty demonstration project; §9305(d) with respect to a review of standards for Medicare conditions of participation for assuring quality of inpatient hospital services; §9305(e) with respect to a study of payment for administratively necessary days; §9305(h) with respect to the development of a uniform needs assessment instrument; §9305(k) with respect to the prior and concurrent authorization demonstration project; §9313(d), as amended by P.L. 100-203, §4085(i)(21), with respect to a study to develop a strategy for quality review and assurance; §9320(j) with respect to the effect of that section on State law provisions; §9335(d) with respect to the reorganization of ESRD network areas and organizations; §9338(d) with respect to a reduction in payment to avoid duplicate payment; §9339(d) with respect to State standards for directors of clinical laboratories; §9342 with respect to Alzheimer's disease demonstration projects; §9353(a)(4) with respect to a small- area analysis; §9412 with respect to the waiver authority for chronically mentally ill and frail elderly; §9413 with respect to the continuation of "case-managed medical care for nursing home patients" demonstration project; and §9436 with respect to payment for certain long-term care patients in hospitals.

See Vol. II, P.L. 99-660, Title IV, with respect to professional review activities.

See Vol. II, P.L. 100-93, §15(f), with respect to treatment of certain denials of payment.

See Vol. II, P.L. 100-203, §4007, with respect to reporting hospital information; §4008(d), with respect to hospital outlier payments and policy; §4018(b)(1) and §4018(b)(4), with respect to the extension of waivers for social health maintenance organizations; §4026(b), with respect to a study and report to Congress which the Secretary shall make on cost limits; §4027, with respect to the home health prospective payment demonstration project for which the Secretary shall provide;

§4031(b), with respect to the prohibition of slowing down claims processing and delaying payment; §4039(f), with respect to the date an entity can be deemed a provider of services; §4039(g), with respect to the use of interim final regulations; §4041(b), with respect to an extension of reduction under the sequester order; §4067(b), with respect to a report on rates for rural health clinic services; §4201(c), with respect to the Secretary's report to Congress on skilled nursing facilities; and §4204(b), with respect to the waiver of paperwork reduction; and §4008(c) [as amended by P.L. 101- 239, §6023(a)], with respect to continuation of bad debt recognition for hospital services, and §4039(d) [as amended by P.L. 101-239, §6207(b)], with respect to the reduction in expenditures in fiscal years 1989 and 1990.

See Vol. II, P.L. 100-204, §724(d), with respect to furnishing information to the United States Commission on Improving the Effectiveness of the United Nations; and §725(b), with respect to the detailing of Government personnel.

See Vol. II, P.L. 100-235, §§5-8, with respect to responsibilities of each Federal agency for computer systems security and privacy.

See Vol. II, P.L. 100-360, §429, with respect to demonstration projects involving chronic ventilator-dependent units in hospitals; and §§401-408 [as amended by P.L. 101-239, §6220], with respect to the U.S. Bipartisan Commission on Comprehensive Health Care.

P.L. 100-360, §§201-208, except §202(g) and (m)(4), were repealed by P.L. 101-234, §201(a)(1), effective January 1, 1990.

P.L. 100-360, §§421-425 and §427, are repealed, effective January 1, 1990, except that the repeal of §421 shall not apply to duplicative part A benefits for periods before January 1, 1990.

See Vol. II, P.L. 100-383, §§105(f)(2) and 206(d)(2), with respect to exclusions from income and resources of certain payments to certain individuals.

See Vol. II, 31 U.S.C. 3803(c)(2)(C), with respect to benefits not affected by P.L. 100-383.

See Vol. II, P.L. 100-407, §105(c), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100-409, §5, with respect to the effect of that Act on P.L. 92-203 or P.L. 96-487.

See Vol. II, P.L. 100-411, §2(d)(3)(B), with respect to the effect of per capita payments.

See Vol. II, P.L. 100-581, §§501, 502(b)(1), and 503, with respect to exclusion from income and resources of certain judgment funds.

See Vol. II, P.L. 100-647, §8411 [as amended by P.L. 101-239, §6205(a)(1)(B)], with respect to treatment of certain nursing education programs.

See Vol. II, P.L. 100-690, §5301(a)(1)(C) and (d)(1)(B), with respect to benefits of drug traffickers and possessors.

See Vol. II, P.L. 100-713, §712, with respect to the provision of services in Montana.

See Vol. II, P.L. 101-121, with respect to the amounts collected by the Secretary of Health and Human Services under the authority of title IV of the Indian Health Care Improvement Act.

See Vol. II, P.L. 101-234, §203(c), with respect to the notice of medicare benefits.

See Vol. II, P.L. 101-239, §6001, with respect to the extension of reductions under original sequester order and applicability of new sequester order; §6025, with respect to a dentist's serving as hospital medical director; §6101, with respect to the extension of reductions under the final sequester order of October 16, 1989; §6107(a), with respect to delaying increases and adjustments in charges or fees for physicians' services and other items and services; §6136, with respect to a study of reimbursement for ambulance services; §6137, with respect to a PROPAC study of payments for services in hospital outpatient departments; §6138, with respect to the Physician Payment Review Commission study of payments for assistants at surgery; §6139, with respect to a GAO study of standards for use of and payment for items of durable medical equipment; §6201, with respect to reductions under the original sequester order and applicability of new sequester order for health maintenance organizations; §6204(e), with respect to a GAO study of ownership by referring physicians; §6205(a)(1)(A) and (a)(2), with respect to recognition of costs of certain hospital-based nursing schools; §6205(b), with respect to a delay in recoupment of certain nursing and allied education costs; §6213(e), with respect to dissemination of rural health clinic information; §6218, with respect to a GAO study of administrative costs of medicare program; §6219(c), with respect to a report on payment for erythropoietin (EPO); §6223, with respect to a study of HCFA personnel; §6901(a), with respect to the moratorium on implementation of the regulation relating to requirements for long-term care facilities; §6901(b)(5)(B), with respect to allocation of costs for nurse aid training by nursing facilities; and §11002, with respect to the restoration of funds sequestered.

See Vol. II, P.L. 101-508, §4002(g)(4), with respect to a PROPAC study and report of medicaid payments to hospitals; §4008(i)(1), with respect to Secretarial waiver authority; §4008(k), with respect to the prospective payment system for skilled nursing facility services; §4008(l), with respect to regulations for rural hospitals; §4111, with respect to a study of prepayment medical review screens; §4151(b)(2), with respect to the prospective payment system for hospital outpatient services; §4161(a)(7), with respect to the GAO study of hospital staff privileges for physicians practicing in community health centers; §4161(b)(3), with respect to productivity screens; §4201(b), with respect to the PROPAC study on ESRD composite rates; §4202, with respect to a staff-assisted home dialysis demonstration project; §4204(b), with respect to the requirements for actuarial equivalence of AAPCC; §4027(sic)(b)(1), with respect to the prohibition of cost savings policies before the beginning of the fiscal year; §4027(sic)(b)(2), with respect to the prohibition of payment cycle changes; §4027(sic)(c), with respect to the development of a prospective payment system for home health services; §4027(sic)(g), with respect to case management demonstration projects; §4027(sic)(k), with respect to regulations on medicare, medicaid, and other health-related programs; §4359, with respect to health insurance advisory service for medicare beneficiaries; §4360, with respect to health insurance information, counseling, and assistance grants; §4801(e)(17)(B), with respect to a study and report on staffing requirements in nursing facilities; §13301, with respect to off-budget status of OASDI trust funds; §13302, with respect to protection of OASDI trust funds in the House of Representatives; and §13303, with respect to social security firewall and point of order in the Senate.

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PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

Sec. 1801. [42 U.S.C. 1395] Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

FREE CHOICE BY PATIENT GUARANTEED

Sec. 1802. [42 U.S.C. 1395a] Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.

OPTION TO INDIVIDUALS TO OBTAIN OTHER HEALTH INSURANCE PROTECTION

SEC. 1803. [42 U.S.C. 1395b] Nothing contained in this title shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services.

NOTICE OF MEDICARE BENEFITS[3]

SEC. 1804. [42 U.S.C. 1395b-2] The Secretary shall prepare (in consultation with groups representing the elderly and with health insurers) and provide for distribution of a notice containing—

(1) a clear, simple explanation of the benefits available under this title and the major categories of health care for which benefits are not available under this title,

(2) the limitations on payment (including deductibles and coinsurance amounts) that are imposed under this title, and

(3) a description of the limited benefits for long-term care services available under this title and generally available under State plans approved under title XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this title and when an individual applies for benefits under part A or enrolls under part B.

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED[4]

DESCRIPTION OF PROGRAM

SEC. 1811. [42 U.S.C. 1395c] The insurance program for which entitlement is established by sections 226 and 226A provides basic protection against the costs of hospital, related post-hospital[5], home health services, and hospice care in accordance with this part for (1) individuals who are age 65 or over and are eligible for retirement benefits under title II of this Act (or would be eligible for such benefits if certain government employment were covered employment under such title) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under title II of this Act (or would have been so entitled to such benefits if certain government employment were covered employment under such title) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

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[3] P.L. 100-360, §223, specified that the Secretary shall first distribute the notice required by §1804 not later than January 31, 1989.

Also see Vol. II, P.L. 101-234, §203(c), with respect to the notice of medicare benefits.

See Vol. II, P.L. 101-239, §6011(b), with respect to determining the payment amount for services to hemophilia inpatients; §6011(c), with respect to recommendations for payments for services to such inpatients; §6014, with respect to a study by the Prospective Payment Assessment Commission on medicare-dependent hospitals; and §6027, with respect to the Massachusetts medicare repayment.

[4] See Vol. II, 38 U.S.C. 5053, with respect to provision of hospital care or medical services by the Veterans' Administration.

See Vol. II, P.L. 97-248, §278(d), with respect to deemed entitlement for hospital insurance benefits purposes.

See Vol. II, P.L. 98-369, §2320, with respect to payment for costs of certain New Jersey hospital-based mobile intensive care units.

See Vol. II, P.L. 99-509, §9302(d)(4) with respect to a rural secondary specialty demonstration project; §9305(e) with respect to a study of payment for administratively necessary days; §9305(k) with respect to the prior and concurrent authorization demonstration project; and §9321(c)(1) with respect to the prohibition of issuance of final regulations on capital-related costs as part of payment for operating costs before September 1, 1987.

See Vol. II, P.L. 100-203, §4001, with respect to the extension of reductions under the final sequester order; §4006(c), with respect to the study and report required from the Prospective Payment Assessment Commission; §4008(a), with respect to the Massachusetts Medicare repayment; and §4039(e), with respect to a moratorium on prior authorization for home health and post-hospital extended care services.

See Vol. II, P.L. 101-508, §4004, with respect to payments for medical education costs; and §4007, with respect to the freeze in payments.

[5] P.L. 101-234, §101(a)(1), struck out "inpatient hospital services, extended care services" and substituted "hospital, related post-hospital", effective January 1, 1990.

SCOPE OF BENEFITS[6]

SEC. 1812. [42 U.S.C. 1395d] (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) inpatient hospital services for up to 150 days during any spell of illness minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made) and inpatient rural primary care hospital services[7];[8]

(2)(A) post-hospital extended care services for up to 100 days during any spell of illness, and (B) to the extent provided in subsection (f), extended care services that are not post-hospital extended care services;[9]

(3) home health services; and[10]

(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each, a subsequent period of 30 days, and a subsequent extension period[11] with respect to which the individual makes an election under subsection (d)(1).[12]

(b) Payment under this part for services furnished an individual during a spell of illness may not (subject to subsection (c)) be made for—

(1) inpatient hospital services furnished to him during such spell after such services have been furnished to him for 150 days

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[6] See Vol. II, P.L. 101-234, §101(b)(1), with respect to applying this section to inpatient hospital services and extended care services provided on or after January 1, 1990.

[7] P.L. 101-239, §6003(g)(3)(B)(i), inserted "and inpatient rural primary care hospital services", effective December 19, 1989.

[8] P.L. 101-234, §101(a)(1), amended this paragraph in its entirety, effective January 1, 1990. [For this paragraph as it formerly read, see Vol. III, P.L. 101-234.]

[9] P.L. 101-234, §101(a)(1), amended this paragraph in its entirety, effective January 1, 1990. [For this paragraph as it formerly read, see Vol. III, P.L. 101-234.]

[10] P.L. 101-234, §101(a)(1), amended this paragraph in its entirety, effective January 1, 1990. [For this paragraph as it formerly read, see Vol. III, P.L. 101-234.]

[11] P.L. 101-508, §4006(a)(1), struck out "and one subsequent period of 30 days" and substituted ", a subsequent period of 30 days, and a subsequent extension period", applicable with respect to care and services furnished on or after January 1, 1990.

[12] P.L. 101-234, §101(a)(1), amended this paragraph in its entirety, effective January 1, 1990. [For this paragraph as it formerly read, see Vol. III, P.L. 101-234.]

This paragraph shall not apply to hospice care provided during the subsequent period (described in §1812 as in effect on December 31, 1989) with respect to which an election has been made before January 1, 1990.

during such spell minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services furnished to him during such spell after such services have been furnished to him for 100 days during such spell; or

(3) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.[13]

(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) insofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b)(3)).[14]

(d)(1) Payment under this part may be made for hospice care provided with respect to an individual only during two periods of 90 days each, a subsequent period of 30 days, and a subsequent extension period[15] during the individual's lifetime and only, with respect to each such period, if the individual makes an election under this paragraph to receive hospice care under this part provided by, or under arrangements made by, a particular hospice program instead of certain other benefits under this title.

(2)(A) Except as provided in subparagraphs (B) and (C) and except in such exceptional and unusual circumstances as the Secretary may provide, if an individual makes such an election for a period with respect to a particular hospice program, the individual shall be deemed to have waived all rights to have payment made under this title with respect to—

(i) hospice care provided by another hospice program (other than under arrangements made by the particular hospice program) during the period, and

(ii) services furnished during the period that are determined (in accordance with guidelines of the Secretary) to be—

(I) related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made or

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[13] P.L. 101-234, §101(a)(1), amended this subsection in its entirety, effective January 1, 1990. [For subsection (b) as it formerly read, see Vol. III, P.L. 101-234.]

[14] P.L. 101-234, §101(a)(1), amended this subsection in its entirety, effective January 1, 1990. [For subsection (c) as it formerly read, see Vol. III, P.L. 101-234.]

[15] P.L. 101-234, §101(a)(1), struck out ", a subsequent period of 30 days, and a subsequent extension period", and substituted "and one subsequent period of 30 days", effective on January 1, 1990.

P.L. 101-508, §4006(a)(2)(A), struck out "and one subsequent period of 30 days" and substituted ", a subsequent period of 30 days, and a subsequent extension period", applicable with respect to care and services furnished on or after January 1, 1990.

(II) equivalent to (or duplicative of) hospice care;

except that clause (ii) shall not apply to physicians' services furnished by the individual's attending physician (if not an employee of the hospice program) or to services provided by (or under arrangements made by) the hospice program.

(B) After an individual makes such an election with respect to a 90- or 30-day period or a subsequent extension period[16], the individual may revoke the election during the period, in which case—

(i) the revocation shall act as a waiver of the right to have payment made under this part for any hospice care benefits for the remaining time in such period and (for purposes of subsection (a)(4) and subparagraph (A)) the individual shall be deemed to have been provided such benefits during such entire period, and

(ii) the individual may at any time after the revocation execute a new election for a subsequent period, if the individual otherwise is entitled to hospice care benefits with respect to such a period.

(C) An individual may, once in each such period, change the hospice program with respect to which the election is made and such change shall not be considered a revocation of an election under subparagraph (B).

(D) For purposes of this title, an individual's election with respect to a hospice program shall no longer be considered to be in effect with respect to that hospice program after the date the individual's revocation or change of election with respect to that election takes effect.

(e) For purposes of subsections (b) and (c), inpatient hospital services, inpatient psychiatric hospital services, and post-hospital[17] extended care services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

(f)(1) The Secretary shall provide for coverage, under clause (B) of subsection (a)(2), of extended care services which are not post-hospital extended care services at such time and for so long as the Secretary determines, and under such terms and conditions (described in paragraph (2)) as the Secretary finds appropriate, that the inclusion of such services will not result in any increase in the total of payments made under this title and will not alter the acute care nature of the benefit decribed in subsection (a)(2).

(2) The Secretary may provide—

(A) for such limitations on the scope and extent of services described in subsection (a)(2)(B) and on the categories of individuals who may be eligible to receive such services, and

(B) notwithstanding sections 1814, 1861(v), and 1886, for such restrictions and alternatives on the amounts and methods of payment for services described in such subsection,

as may be necessary to carry out paragraph (1).[18]

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[16] P.L. 101-234, §101(a)(1), struck out "or a subsequent extension period", effective January 1, 1990.

P.L. 101-508, §4006(a)(2)(B), inserted "or a subsequent extension period", applicable with respect to care and services furnished on or after January 1, 1990.

[17] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.

[18] P.L. 101-234, §101(a)(1), added subsection (f), effective January 1, 1990.

(g) For definition of "spell of illness", and for definitions of other terms used in this part, see section 1861.[19]

DEDUCTIBLES AND COINSURANCE[20]

SEC. 1813. [42 U.S.C. 1395e] (a)(1) The amount payable for inpatient hospital services furnished an individual during any spell of illness shall be reduced by a deduction equal to the inpatient hospital deductible or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed. Such amount shall be further reduced by a coinsurance amount equal to—

(A) one-fourth of the inpatient hospital deductible for each day (before the 91st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 60 days during such spell; and

(B) one-half of the inpatient hospital deductible for each day (before the day following the last day for which such individual is entitled under section 1812(a)(1) to have payment made on his behalf for inpatient hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such services (and for this purpose, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed).[21]

(2)(A) The amount payable to any provider of services under this part for services furnished an individual shall be further reduced by a deduction equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during each calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

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[19] P.L. 101-234, §101(a)(1), added subsection (g), effective January 1, 1990.

[20] See Vol. II, P.L. 99-272, §9128, with respect to the sense of the Senate concerning the inpatient hospital deductible.

See Vol. II, P.L. 101-234, §101(b)(1), with respect to applying this section to inpatient hospital services and extended care services provided on or after January 1, 1990.

[21] P.L. 101-234, §101(a)(1), amended this paragraph in its entirety, effective January 1, 1990. For the applicability of this amendment, see Vol. II, P.L. 100-360, §104(a) and (b) [as amended by P.L. 101-234, §101(b)(3)]; and P.L. 101-234, §101(b)(1). [For this paragraph as it formerly read, see Vol. III, P.L. 101-234.]

(B) The deductible under subparagraph (A) for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1833(b) to blood or blood cells furnished the individual in the year.

(3) The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day (before the 101st day) on which he is furnished such services after such services have been furnished to him for 20 days during such spell.[22]

(4)(A) The amount payable for hospice care shall be reduced—

(i) in the case of drugs and biologicals provided on an outpatient basis by (or under arrangements made by) the hospice program, by a coinsurance amount equal to an amount (not to exceed $5 per prescription) determined in accordance with a drug copayment schedule (established by the hospice program) which is related to, and approximates 5 percent of, the cost of the drug or biological to the program, and

(ii) in the case of respite care provided by (or under arrangements made by) the hospice program, by a coinsurance amount equal to 5 percent of the amount estimated by the hospice program (in accordance with regulations of the Secretary) to be equal to the amount of payment under section 1814(i) to that program for respite care;

except that the total of the coinsurance required under clause (ii) for an individual may not exceed for a hospice coinsurance period the inpatient hospital deductible applicable for the year in which the period began. For purposes of this subparagraph, the term "hospice coinsurance period" means, for an individual, a period of consecutive days beginning with the first day for which an election under section 1812(d) is in effect for the individual and ending with the close of the first period of 14 consecutive days on each of which such an election is not in effect for the individual.

(B) During the period of an election by an individual under section 1812(d)(1), no copayments or deductibles other than those under subparagraph (A) shall apply with respect to services furnished to such individual which constitute hospice care, regardless of the setting in which such services are furnished.

(b)(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the Secretary's best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1886(b)(3)(B)) which are applied under section 1886(d)(3)(A) for discharges in the fiscal year that begins on October 1 of such preceding calendar year, and adjusted to reflect changes in real case mix (determined on the basis of the most recent case mix data available). Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiples of $4, to the next higher multiple of $4).

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[22] P.L. 101-234, §101(a)(1), amended this paragraph in its entirety, effective January 1, 1990. For the applicability of this amendment, see Vol. II, P.L. 100-360, §104(a) and (b) [as amended by P.L. 101-234, §101(b)(3)]; and P.L. 101-234, §101(b)(1). [For this paragraph as it formerly read, see Vol. III, P.L. 101-234.]

(2) The Secretary shall promulgate the inpatient hospital deductible and all coinsurance amounts under this section between September 1 and September 15 of the year preceding the year to which they will apply.

(3) The inpatient hospital deductible for a year shall apply to—

(A) the deduction under the first sentence of subsection (a)(1) for the year in which the first day of inpatient hospital services occurs in a spell of illness, and

(B) to the coinsurance amounts under subsection (a) for inpatient hospital services and post-hospital extended care services furnished in that year.[23]

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. [42 U.S.C. 1395f] (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;

(2) a physician, or, in the case of services described in subparagraph (B), a physician, or a nurse practitioner or clinical nurse specialist who does not have a direct or indirect employment relationship with the facility but is working in collaboration with a physician,[24] certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

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[23] P.L. 101-234, §101(a)(1), added paragraph (3), effective January 1, 1990.

[24] P.L. 101-239, §6028(1), inserted ", or, in the case of services described in subparagraph (B), a physician, or a nurse practitioner or clinical nurse specialist who does not have a direct or indirect employment relationship with the facility but is working in collaboration with a physician,", effective December 19, 1989.

(B) in the case of post-hospital[25] extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services[26];

(C) in the case of home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needs or needed skilled nursing care on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; or

(D) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services;

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause[27] (A) shall be furnished no later than the 20th day of such period;

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[25] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.

[26] P.L. 101-234, §101(a)(1), inserted ", for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services", effective January 1, 1990.

[27] As in original. Possibly should be "subparagraph".

(4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

(5) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services and with respect to post-hospital extended care services furnished after such day of a continuous period of such services as may be prescribed in or pursuant to regulations, there was not in effect, at the time of admission of such individual to the hospital or skilled nursing facility, as the case may be, a decision under section 1866(d) (based on a finding that utilization review of long-stay cases is not being made in such hospital or facility);

(6) with respect to inpatient hospital services or post-hospital[28] extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861(k)(4), including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization review that further inpatient hospital services or further post-hospital[29] extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding;[30]

(7) in the case of hospice care provided an individual—

(A)(i) in the first 90-day period—

(I) the individual's attending physician (as defined in section 1861(dd)(3)(B)), and

(II) the medical director (or physician member of the interdisciplinary group described in section 1861(dd)(2)(B)) of the hospice program providing (or arranging for) the care,

each certify in writing, not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated),[31] that the individual is terminally ill (as defined in section 1861(dd)(3)(A)),[32]

(ii) in a subsequent 90- or 30-day period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill, and[33]

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[28] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.

[29] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.

[30] P.L. 101-239, §6003(g)(3)(B)(ii)(I), struck out "and".

[31] P.L. 101-239, §6005(b), struck out ", not later than two days after hospice care is initiated," and substituted "in writing, not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated),", effective with respect to care and services furnished on or after January 1, 1990*.

*P.L. 101-508, §4008(m)(3)(B), amended the effective date for §6005(b).

[32] P.L. 101-234, §101(a)(1), inserted "and".

P.L. 101-508, §4006(b)(1), struck out "and".

[33] P.L. 101-234, §101(a)(1), struck out ", and" and substituted a semicolon.

P.L. 101-508, §4006(b)(2), struck out a semicolon and substituted ", and".

(iii) in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;[34]

(B) a written plan for providing hospice care with respect to such individual has been established (before such care is provided by, or under arrangements made by, that hospice program) and is periodically reviewed by the individual's attending physician and by the medical director (and the interdisciplinary group described in section 1861(dd)(2)(B)) of the hospice program; and

(C) such care is being or was provided pursuant to such plan of care; and[35]

(8) in the case of inpatient rural primary care hospital services, a physician certifies that such services were required to be immediately furnished on a temporary, inpatient basis.[36]

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician, nurse practitioner, or clinical nurse specialist (as the case may be)[37] makes certification of the kind provided in subparagraph (A), (B), (C), or (D) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of paragraph (2)(C), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences of the individual from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.

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[34] P.L. 101-234, §101(a)(1), struck out clause (iii), effective January 1, 1990.

P.L. 101-508, §4006(b)(3), restored clause (iii), applicable with respect to care and services furnished on or after January 1, 1990. Margin as in original.

[35] P.L. 101-239, §6003(g)(3)(B)(ii)(II), struck out the period and substituted "; and".

[36] P.L. 101-239, §6003(g)(3)(B)(ii)(III), added this paragraph, effective December 19, 1989.

[37] P.L. 101-239, §6028(2), inserted ", nurse practitioner, or clinical nurse specialist (as the case may be)", effective December 19, 1989.

Amount Paid to Providers

(b) The amount paid to any provider of services (other than a hospice program providing hospice care, other than a rural primary care hospital providing inpatient rural primary care hospital services,[38] and other than a home health agency with respect to durable medical equipment) with respect to services for which payment may be made under this part shall, subject to the provisions of sections 1813 and 1886, be—

(1) except as provided in paragraph (3), the lesser of (A) the reasonable cost of such services, as determined under section 1861(v) and as further limited by section 1881(b)(2)(B), or (B) the customary charges with respect to such services;

(2) if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this paragraph), free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services; or[39]

(3) if some or all of the hospitals in a State have been reimbursed for services (for which payment may be made under this part) pursuant to a reimbursement system approved as a demonstration project under section 402 of the Social Security Amendments of 1967[40] or section 222 of the Social Security Amendments of 1972[41], if the rate of increase in such hospitals in their costs per hospital inpatient admission of individuals entitled to benefits under this part over the duration of such project was equal to or less than such rate of increase for admissions of such individuals with respect to all hospitals in the United States during such period, and if either the State has legislative authority to operate such system and the State elects to have reimbursement to such hospitals made in accordance with this paragraph or the system is operated through a voluntary agreement of hospitals and such hospitals elect to have reimbursement to those hospitals made in accordance with this paragraph, then the Secretary may provide for continuation of reimbursement to such hospitals under such system until the Secretary determines that—

(A) a third-party payor reimburses such a hospital on a basis other than under such system, or

(B) the aggregate rate of increase from January 1, 1981[42], to the most recent date for which annual data are available in such hospitals in costs per hospital inpatient admission of individuals entitled to benefits under this part is greater than such rate of increase for admissions of such individuals with respect to all hospitals in the United States for such period.[43]

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[38] P.L. 101-239, §6003(g)(3)(B)(iii)(I), inserted ", other than a rural primary care hospital providing inpatient rural primary care hospital services,", effective December 19, 1989.

[39] See Vol. II, P.L. 98-369, §2308(b)(1), with respect to rules applicable to the nominality test.

[40] P.L. 90-248.

[41] P.L. 92-603.

[42] P.L. 101-508, §4008(i)(3)(A), struck out "October 1, 1983" and substituted "January 1, 1981", effective November 5, 1990.

In the case of any State which has had such a demonstration project reimbursement system in continuous operation since July 1, 1977, the Secretary shall provide under paragraph (3) for continuation of reimbursement to hospitals in the State under such system until the first day of the 37th[44] month beginning after the date the Secretary determines and notifies the Governor of the State that either of the conditions described in subparagraph (A) or (B) of such paragraph has occurred. If, by the end of such 36-month period, the Secretary determines, based on evidence submitted by the Governor of the State, that neither of the conditions described in subparagraph (A) or (B) of paragraph (3) continues to apply, the Secretary shall continue without interruption payment to hospitals in the State under the State's system.[45] If, by the end of such 36-month period, the Secretary determines, based on such evidence, that either of the conditions described in subparagraph (A) or (B) of such paragraph continues to apply, the Secretary shall (i) collect any net excess reimbursement to hospitals in the State during such 36-month period (basing such net excess reimbursement on the net difference, if any, in the rate of increase in costs per hospital inpatient admission under the State system compared to the rate of increase in such costs with respect to all hospitals in the United States over the 36-month period, as measured by including the cumulative savings under the State system based on the difference in the rate of increase in costs per hospital inpatient admission under the State system as compared to the rate of increase in such costs with respect to all hospitals in the United States between January 1, 1981, and the date of the Secretary's initial notice), and (ii) provide a reasonable period, not to exceed 2 years, for transition from the State system to the national payment system.[46]

No Payments to Federal Providers of Services[47]

(c) Subject to section 1880, no payment may be made under this part (except under subsection (d) or subsection (h)) to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

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[43] See Vol. II, P.L. 100-203, §4015, with respect to Medicare payment demonstration projects, and §4027, with respect to the home health prospective payment demonstration project for which the Secretary shall provide.

[44] P.L. 101-508, §4008(i)(3)(B), struck out "seventh" and substituted "37th", effective November 5, 1990.

[45] P.L. 101-508, §4008(i)(3)(C), added this sentence, effective November 5, 1990.

[46] P.L. 101-508, §4008(i)(3)(C), added this sentence, effective November 5, 1990.

[47] See Vol. II, 38 U.S.C. 5053, with respect to care or service furnished by a Veterans' Administration facility to a Title XVIII beneficiary who is not eligible for Veterans' Administration benefits.

Payments for Emergency Hospital Services

(d)(1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year, by the hospital or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital insurance benefits under section 226 even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has elected to claim payments for all such inpatient emergency services and for the emergency outpatient services referred to in section 1835(b) furnished during such year. Such payments shall be made only in the amounts provided under subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1866(a).

(2) Payment may be made on the basis of an itemized bill to an individual entitled to hospital insurance benefits under section 226 for services described in paragraph (1) which are emergency services if (A) payment cannot be made under paragraph (1) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement.

(3) The amounts payable under the preceding paragraph with respect to services described therein shall, subject to the provisions of section 1813, be equal to 60[48] percent of the hospital's reasonable charges for routine services furnished in the accommodations occupied by the individual or in semiprivate accommodations (as defined in section 1861(v)(4)), whichever is less, plus 80[49] percent of the hospital's reasonable charges for ancillary services. If separate charges for routine and ancillary services are not made by the hospital, reimbursement may be based on two-thirds of[50] the hospital's reasonable charges for the services received but not to exceed the charges which would have been made if the patient had occupied semiprivate accommodations. For purposes of the preceding provisions of this paragraph, the term "routine services" shall mean the regular room, dietary, and nursing services, minor medical and surgical supplies and the use of equipment and facilities for which a separate charge is not customarily made; the term "ancillary services" shall mean those special services for which charges are customarily made in addition to routine services.

Payment for Inpatient Hospital Services Prior to Notification of Noneligibility

(e) Notwithstanding that an individual is not entitled to have payment made under this part for inpatient hospital services furnished by any hospital, payment shall be made to such hospital (unless it elects not to receive such payment or, if payment has already been made by or on behalf of such individual, fails to refund such payment within the time specified by the Secretary) for such services which are furnished to the individual prior to notification to such hospital from the Secretary of his lack of entitlement, if such payments are precluded only by reason of section 1812 and if such hospital complies with the requirements of and regulations under this title with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed. Payment under the preceding sentence may not be made for services furnished an individual pursuant to any admission after the 6th elapsed day (not including as an elapsed day Saturday, Sunday, or a legal holiday) after the day on which such admission occurred.

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[48] P.L. 101-234, §101(a)(1), struck out "100" and substituted "60", effective January 1, 1990.

[49] P.L. 101-234, §101(a)(1), struck out "100" and substituted "80", effective January 1, 1990.

[50] P.L. 101-234, §101(a)(1), inserted "two-thirds of", effective January 1, 1990.

Payment for Certain Inpatient Hospital Services Furnished Outside the United States

(f)(1) Payment shall be made for inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States, or under arrangements (as defined in section 1861(w)) with it, if—

(A) such individual is a resident of the United States, and

(B) such hospital was closer to, or substantially more accessible from, the residence of such individual than the nearest hospital within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

(2) Payment may also be made for emergency inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States if—

(A) such individual was physically present—

(i) in a place within the United States; or

(ii) at a place within Canada while traveling without unreasonable delay by the most direct route (as determined by the Secretary) between Alaska and another State;

at the time the emergency which necessitated such inpatient hospital services occurred, and

(B) such hospital was closer to, or substantially more accessible from, such place than the nearest hospital within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

(3) Payment shall be made in the amount provided under subsection (b) to any hospital for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual by the hospital or under arrangements (as defined in section 1861(w)) with it if (A) the Secretary would be required to make such payment if the hospital had an agreement in effect under this title and otherwise met the conditions of payment hereunder, (B) such hospital elects to claim such payment, and (C) such hospital agrees to comply, with respect to such services, with the provisions of section 1866(a).

(4) Payment for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual entitled to hospital insurance benefits under section 226 may be made on the basis of an

itemized bill to such individual if (A) payment for such services cannot be made under paragraph (3) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and continuing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amount payable with respect to such services shall, subject to the provisions of section 1813, be equal to the amount which would be payable under subsection (d)(3).

Payment for Services of a Physician Rendered in a Teaching Hospital

(g) For purposes of services for which the reasonable cost thereof is determined under section 1861(v)(1)(D) (or would be if section 1886 did not apply), payment under this part shall be made to such fund as may be designated by the organized medical staff of the hospital in which such services were furnished or, if such services were furnished in such hospital by the faculty of a medical school, to such fund as may be designated by such faculty, but only if—

(1) such hospital has an agreement with the Secretary under section 1866, and

(2) the Secretary has received written assurances that (A) such payment will be used by such fund solely for the improvement of care of hospital patients or for educational or charitable purposes and (B) the individuals who were furnished such services or any other persons will not be charged for such services (or if charged, provision will be made for return of any moneys incorrectly collected).

Payment for Certain Hospital Services Provided in Veterans' Administration Hospitals

(h)(1) Payments shall also be made to any hospital operated by the Veterans' Administration for inpatient hospital services furnished in a calendar year by the hospital, or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital benefits under section 226 even though the hospital is a Federal provider of services if (A) the individual was not entitled to have the services furnished to him free of charge by the hospital, (B) the individual was admitted to the hospital in the reasonable belief on the part of the admitting authorities that the individual was a person who was entitled to have the services furnished to him free of charge, (C) the authorities of the hospital, in admitting the individual, and the individual, acted in good faith, and (D) the services were furnished during a period ending with the close of the day on which the authorities operating the hospital first became aware of the fact that the individual was not entitled to have the services furnished to him by the hospital free of charge, or (if later) ending with the first day on which it was medically feasible to remove the individual from the hospital by discharging him therefrom or transferring him to a hospital which has in effect an agreement under this title.

(2) Payment for services described in paragraph (1) shall be in an amount equal to the charge imposed by the Veterans' Administration for such services, or (if less) the amount that would be payable

for such services under subsection (b) and section 1886 (as estimated by the Secretary). Any such payment shall be made to the entity to which payment for the services involved would have been payable, if payment for such services had been made by the individual receiving the services involved (or by another private person acting on behalf of such individual).

Payment for Hospice Care[51]

(i)(1)(A) Subject to the limitation under paragraph (2) and the provisions of section 1813(a)(4) and except as otherwise provided in this paragraph[52], the amount paid to a hospice program with respect to hospice care for which payment may be made under this part shall be an amount equal to the costs which are reasonable and related to the cost of providing hospice care or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations (including those authorized under section 1861(v)(1)(A)), except that no payment may be made for bereavement counseling and no reimbursement may be made for other counseling services (including nutritional and dietary counseling) as separate services.

(B) Notwithstanding subparagraph (A), for hospice care furnished on or after April 1, 1986, the daily rate of payment per day for routine home care shall be $63.17 and the daily rate of payment for other services included in hospice care shall be the daily rate of payment recognized under subparagraph (A) as of July 1, 1985, increased by $10.

(C)(i) With respect to routine home care and other services included in hospice care furnished on or after January 1, 1990, and on or before September 30, 1990,[53], the payment rates for such care and services shall be 120 percent of such rates in effect as of September 30, 1989.

(ii) With respect to routine home care and other services included in hospice care furnished during a subsequent fiscal year, the payment rates for such care and services shall be the payment rates in effect under this subparagraph during the previous fiscal year increased by the market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) otherwise applicable to discharges occurring in the fiscal year.[54]

(2)(A) The amount of payment made under this part for hospice care provided by (or under arrangements made by) a hospice program for an accounting year may not exceed the "cap amount" for the year (computed under subparagraph (B)) multiplied by the number of medicare beneficiaries in the hospice program in that year (determined under subparagraph (C)).

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[51] See Vol. II, P.L. 101-239, §6016, with respect to a study of methods to compensate hospices for high-cost care.

[52] P.L. 101-239, §6005(a)(1), inserted "and except as otherwise provided in this paragraph", effective with respect to care and services furnished on or after January 1, 1990.

[53] P.L. 101-508, §4008(m)(3)(A), struck out "during fiscal year 1990" and substituted "on or after January 1, 1990, and on or before September 30, 1990,", effective November 5, 1990.

As in original; one comma should be stricken.

[54] P.L. 101-239, §6005(a)(2), amended subparagraph (C) in its entirety, effective with respect to care and services furnished on or after January 1, 1990. [For subparagraph (C) as it formerly read, see Vol. III, P.L. 101-239.] For hospice care furnished on or after April 1, 1986, the following daily rates of payment apply: For routine home care, $63.17; for continuous home care, $368.67; for inpatient respite care, $65.33; and for general inpatient care, $281.00. (51 FR 36066, October 8, 1986)

(B) For purposes of subparagraph (A), the "cap amount" for a year is $6,500, increased or decreased, for accounting years that end after October 1, 1984, by the same percentage as the percentage increase or decrease, respectively, in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year.[55]

(C) For purposes of subparagraph (A), the "number of medicare beneficiaries" in a hospice program in an accounting year is equal to the number of individuals who have made an election under subsection (d) with respect to the hospice program and have been provided hospice care by (or under arrangements made by) the hospice program under this part in the accounting year, such number reduced to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year or under a plan of care established by another hospice program.

Elimination of Lesser-of-Cost-or-Charges Provision

(j)(1) The lesser-of-cost-or-charges provisions (described in paragraph (2)) will not apply in the case of services provided by a class of provider of services if the Secretary determines and certifies to Congress that the failure of such provisions to apply to the services provided by that class of providers will not result in any increase in the amount of payments made for those services under this title. Such change will take effect with respect to services furnished, or cost reporting periods of providers, on or after such date as the Secretary shall provide in the certification. Such change for a class of provider shall be discontinued if the Secretary determines and notifies Congress that such change has resulted in an increase in the amount of payments made under this title for services provided by that class of provider.

(2) The lesser-of-cost-or-charges provisions referred to in paragraph (1) are as follows:

(A) Clause (B) of paragraph (1) and paragraph (2) of subsection (b).

(B) Section 1834(a)(1)(B).[56]

(C) So much of subparagraph (A) of section 1833(a)(2) as provides for payment other than of the reasonable cost of such services, as determined under section 1861(v).

(D) Subclause (II) of clause (i) and clause (ii) of section 1833(a)(2)(B).

Payments to Home Health Agencies for Durable Medical Equipment

(k) The amount paid to any home health agency with respect to durable medical equipment for which payment may be made under this part shall be the amount described in section 1834(a)(1).[57]

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[55] The payment cap for November 1, 1988, through October 31, 1989, is $9,010. (54 FR 39815, September 28, 1989).

[56] P.L. 100-203, §4062 [as amended by P.L. 101-508, §4152(h)], amended subparagraph (B) in its entirety, applicable to covered items (other than oxygen and oxygen equipment) furnished on or after January 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989.

[57] P.L. 100-203, §4062 [as amended by P.L. 101-508, §4152(h)], amended subsection (k), applicable to covered items (other than oxygen and oxygen equipment) furnished on or after January 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989.

Payment for Inpatient Rural Primary Care Hospital Services[58]

(l)(1) The amount of payment under this part for inpatient rural primary care hospital services—

(A) in the case of the first 12-month cost reporting period for which the facility operates as such a hospital, is the reasonable costs of the facility in providing inpatient rural primary care hospital services during such period, as such costs are determined on a per diem basis, and

(B) in the case of a later reporting period, is the per diem payment amount established under this paragraph for the preceding 12-month cost reporting period, increased by the applicable percentage increase under section 1886(b)(3)(B)(i) for that particular cost reporting period applicable to hospitals located in a rural area.

The payment amounts otherwise determined under this paragraph shall be reduced, to the extent necessary, to avoid duplication of any payment made under section 1820(a)(2) (or under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987[59]) to cover the provision of inpatient rural primary care hospital services.

(2) The Secretary shall develop a prospective payment system for determining payment amounts for inpatient rural primary care hospital services under this part furnished on or after January 1, 1993.

PAYMENT TO PROVIDERS OF SERVICES[60]

SEC. 1815. [42 U.S.C. 1395g] (a) The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

(b) No payment shall be made to a provider of services which is a hospital for or with respect to services furnished by it for any period with respect to which it is deemed, under section 1861(w)(2), to have in effect an arrangement with a quality control and peer review organization for the conduct of utilization review activities by such organization unless such hospital has paid to such organization the amount due (as determined pursuant to such section) to such organization for the review activities conducted by it pursuant to such arrangements or such hospital has provided assurances satisfactory to the Secretary that such organization will promptly be paid the amount so due to it from the proceeds of the payment claimed by the hospital. Payment under this title for utilization review activities provided by a quality control and peer review organization pursuant to an arrangement or deemed arrangement with a hospital under section 1861(w)(2) shall be calculated without any requirement that the reasonable cost of such activities be apportioned among the patients of such hospital, if any, to whom such activities were not applicable.

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[58] P.L. 101-239, §6003(g)(3)(B)(iii)(II), added subsection (l), effective December 19, 1989.

[59] P.L. 101-203.

[60] See Vol. II, P.L. 97-248, §111, with respect to regulations concerning elimination of private room subsidy.

(c) No payment which may be made to a provider of services under this title for any service furnished to an individual shall be made to any other person under an assignment or power of attorney; but nothing in this subsection shall be construed (1) to prevent the making of such a payment in accordance with an assignment from the provider if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (2) to preclude an agent of the provider of services from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such provider under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

(d) Whenever a final determination is made that the amount of payment made under this part to a provider of services was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments.

(e)(1) The Secretary shall provide payment under this part for inpatient hospital services furnished by a subsection (d) hospital (as defined in section 1886(d)(1)(B), and including a distinct psychiatric or rehabilitation unit of such a hospital) and a subsection (d) Puerto Rico hospital (as defined in section 1886(d)(9)(A)) on a periodic interim payment basis (rather than on the basis of bills actually submitted) in the following cases:

(A) Upon the request of a hospital which is paid through an agency or organization with an agreement with the Secretary under section 1816, if the agency or organization, for three consecutive calendar months, fails to meet the requirements of subsection (c)(2) of such section and if the hospital meets the requirements (in effect as of October 1, 1986) applicable to payment on such a basis, until such time as the agency or organization meets such requirements for three consecutive calendar months.

(B) In the case of[61] hospital that—

(i) has a disproportionate share adjustment percentage (as established in clause (iv) of such section)[62] of at least 5.1 percent (as computed for purposes of establishing the average standardized amounts for discharges occurring during fiscal year 1987), and

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[61] As in original.

[62] See §1886(d)(5)(F)(iv).

(ii) requests payment on such basis,

but only if the hospital was being paid for inpatient hospital services on such a periodic interim payment basis as of June 30, 1987, and continues to meet the requirements (in effect as of October 1, 1986) applicable to payment on such a basis.

(C) In the case of a hospital that—

(i) is located in a rural area,

(ii) has 100 or fewer beds, and

(iii) requests payment on such basis,

but only if the hospital was being paid for inpatient hospital services on such a periodic interim payment basis as of June 30, 1987, and continues to meet the requirements (in effect as of October 1, 1986) applicable to payment on such a basis.

(2) The Secretary shall provide (or continue to provide) for payment on a periodic interim payment basis (under the standards established under section 405.454(j) of title 42, Code of Federal Regulations, as in effect on October 1, 1986) with respect to—

(A) inpatient hospital services of a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B));

(B) a hospital which is receiving payment under a State hospital reimbursement system under section 1814(b)(3) or 1886(c), if payment on a periodic interim payment basis is an integral part of such reimbursement system;

(C) extended care services;

(D) home health services; and

(E) hospice care;

if the provider of such services elects to receive, and qualifies for, such payments.

(3) In the case of a subsection (d) hospital or a subsection (d) Puerto Rico hospital (as defined for purposes of section 1886) which has significant cash flow problems resulting from operations of its intermediary or from unusual circumstances of the hospital's operation, the Secretary may make available appropriate accelerated payments.

(4) A hospital created by the merger or consolidation of 2 or more hospitals or hospital campuses shall be eligible to receive periodic interim payment on the basis described in paragraph (1)(B) if—

(A) at least one of the hospitals or campuses received periodic interim payment on such basis prior to the merger or consolidation; and

(B) the merging or consolidating hospitals or campuses would each meet the requirement of paragraph (1)(B)(i) if such hospitals or campuses were treated as independent hospitals for purposes of this title.[63]

USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES[64]

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[63] P.L. 101-239, §6021(a), added paragraph (4), applicable to payments made for discharges occurring on or after January 18, 1990, regardless of the date of the merger or consolidation involved.

[64] See Vol. II, P.L. 97-248, §118, with respect to funds for audit and medical claims review.

See Vol. II, P.L. 99-509, §9311(d)(3) with respect to the Secretary's responsibilities.

See Vol. II, P.L. 100-203, §4031(a)(3)(B) and §4032(c)(2), with respect to the responsibilities of the Secretary and §4031(c), with respect to budget considerations.

See Vol. II, P.L. 101-508, §4005(c)(3), with respect to guidance for intermediaries and hospitals.

SEC. 1816. **[42 U.S.C. 1395h]** (a) If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the agreement) of the amount of the payments required pursuant to this part to be made to such providers (and to providers assigned to such agency or organization under subsection (e)), and for the making of such payments by such agency or organization to such providers (and to providers assigned to such agency or organization under subsection (e)). Such agreement may also include provision for the agency or organization to do all or any part of the following: (1) to provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this part and otherwise to qualify as hospitals, extended care facilities, or home health agencies, and (2) with respect to the providers of services which are to receive payments through it (A) to serve as a center for, and communicate to providers, any information or instructions furnished to it by the Secretary, and serve as a channel of communication from providers to the Secretary; (B) to make such audits of the records of providers as may be necessary to insure that proper payments are made under this part; and (C) to perform such other functions as are necessary to carry out this subsection. As used in this title and part B of title XI, the term "fiscal intermediary" means an agency or organization with a contract under this section.

(b) The Secretary shall not enter into or renew an agreement with any agency or organization under this section unless—

(1) he finds—

(A) after applying the standards, criteria, and procedures developed under subsection (f), that to do so is consistent with the effective and efficient administration of this part, and

(B) that such agency or organization is willing and able to assist the providers to which payments are made through it under this part in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits under section 226, and the agreement provides for such assistance; and

(2) such agency or organization agrees—

(A) to furnish to the Secretary such of the information acquired by it in carrying out its agreement under this section, and

(B) to provide the Secretary with access to all such data, information, and claims processing operations,

as the Secretary may find necessary in performing his functions under this part.

(c)(1) An agreement with any agency or organization under this section may contain such terms and conditions as the Secretary finds necessary or appropriate, may provide for advances of funds to the agency or organization for the making of payments by it under subsection (a), and shall provide for payment of so much of the cost of administration of the agency or organization as is determined by the Secretary to be necessary and proper for carrying out the functions covered by the agreement. The Secretary shall provide that in determining the necessary and proper cost of administration, the Secretary shall, with respect to each agreement, take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated agency or organization in carrying out the terms of its agreement. The Secretary shall cause to have published in the Federal Register, by not later than September 1 before each fiscal year, data, standards, and methodology to be used to establish budgets for fiscal intermediaries under this section for that fiscal year, and shall cause to be published in the Federal Register for public comment, at least 90 days before such data, standards, and methodology are published, the data, standards, and methodology proposed to be used. The Secretary may not require, as a condition of entering into or renewing an agreement under this section or under section 1871, that a fiscal intermediary match data obtained other than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which the provisions of section 1862(b) may apply.[65]

(2)(A) Each agreement under this section shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to not less than 95 percent of all claims submitted under this title—

(i) which are clean claims, and

(ii) for which payment is not made on a periodic interim payment basis,

within the applicable number of calendar days after the date on which the claim is received.

(B) In this paragraph:

(i) The term "clean claim" means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this title.

(ii) The term "applicable number of calendar days" means—

(I) with respect to claims received in the 12-month period beginning October 1, 1986, 30 calendar days,

(II) with respect to claims received in the 12-month period beginning October 1, 1987, 26 calendar days,

(III) with respect to claims received in the 12-month period beginning October 1, 1988, 25 calendar days, and

(IV) with respect to claims received in the 12-month period beginning October 1, 1989, and claims received in any succeeding 12-month period, 24 calendar days.

(C) If payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in clause (ii) of subparagraph (B)) after a clean claim (as defined in clause (i) of such subparagraph) is received from a hospital, rural primary care hospital,[66] skilled nursing facility, home health agency, hospice program, comprehensive outpatient rehabilitation facility, or rehabilitation agency that is not receiving payments on a periodic interim payment basis with respect to such services, interest shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made.

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[65] P.L. 101-239, §6202(d)(1), added this sentence, applicable to agreements and contracts entered into or renewed on or after December 19, 1989.

(3)(A) Each agreement under this section shall provide that no payment shall be issued, mailed, or otherwise transmitted with respect to any claim submitted under this title within the applicable number of calendar days after the date on which the claim is received.

(B) In this paragraph, the term "applicable number of calendar days" means—

(i) with respect to claims received in the 3-month period beginning July 1, 1988, 10 days, and

(ii) with respect to claims received in the 12-month period beginning October 1, 1988, 14 days.

(d) If the nomination of an agency or organization as provided in this section is made by a group or association of providers of services, it shall not be binding on members of the group or association which notify the Secretary of their election to that effect. Any provider may, upon such notice as may be specified in the agreement under this section with an agency or organization, withdraw its nomination to receive payments through such agency or organization. Any provider which has withdrawn its nomination, and any provider which has not made a nomination, may elect to receive payments from any agency or organization which has entered into an agreement with the Secretary under this section if the Secretary and such agency or organization agree to it.

(e)(1) Notwithstanding subsections (a) and (d), the Secretary, after taking into consideration any preferences of providers of services, may assign or reassign any provider of services to any agency or organization which has entered into an agreement with him under this section, if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such assignment or reassignment would result in the more effective and efficient administration of this part.

(2) Notwithstanding subsections (a) and (d), the Secretary may (subject to the provisions of paragraph (4)) designate a national or regional agency or organization which has entered into an agreement with him under this section to perform functions under the agreement with respect to a class of providers of services in the Nation or region (as the case may be), if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such designation would result in more effective and efficient administration of this part.

(3)(A) Before the Secretary makes an assignment or reassignment under paragraph (1) of a provider of services to other than the agency or organization nominated by the provider, he shall furnish (i) the provider and such agency or organization with a full explanation of the reasons for his determination as to the efficiency and effectiveness of the agency or organization to perform the functions required under this part with respect to the provider, and (ii) such agency or organization with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

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[66] P.L. 101-239, §6003(g)(3)(D)(vi), inserted "rural primary care hospital,", effective December 19, 1989.

(B) Before the Secretary makes a designation under paragraph (2) with respect to a class of providers of services, he shall furnish (i) such providers and the agencies and organizations adversely affected by such designation with a full explanation of the reasons for his determination as to the efficiency and effectiveness of such agencies and organizations to perform the functions required under this part with respect to such providers, and (ii) the agencies and organizations adversely affected by such designation with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

(4) Notwithstanding subsections (a) and (d) and paragraphs (1), (2), and (3) of this subsection, the Secretary shall designate regional agencies or organizations which have entered into an agreement with him under this section to perform functions under such agreement with respect to home health agencies (as defined in section 1861(o)) in the region, except that in assigning such agencies to such designated regional agencies or organizations the Secretary shall assign a home health agency which is a subdivision of a hospital (and such agency and hospital are affiliated or under common control) only if, after applying such criteria relating to administrative efficiency and effectiveness as he shall promulgate, he determines that such assignment would result in the more effective and efficient administration of this title. By not later than July 1, 1987, the Secretary shall limit the number of such regional agencies or organizations to not more than ten.

(5) Notwithstanding any other provision of this title, the Secretary shall designate the agency or organization which has entered into an agreement under this section to perform functions under such an agreement with respect to each hospice program, except that with respect to a hospice program which is a subdivision of a provider of services (and such hospice program and provider of services are under common control) due regard shall be given to the agency or organization which performs the functions under this section for the provider of services.

(f)(1)[67] In order to determine whether the Secretary should enter into, renew, or terminate an agreement under this section with an agency or organization, whether the Secretary should assign or reassign a provider of services to an agency or organization, and whether the Secretary should designate an agency or organization to perform services with respect to a class of providers of services, the Secretary shall develop standards, criteria, and procedures to evaluate such agency's or organization's (A)[68] overall performance of claims processing and other related functions required to be performed by such an agency or organization under an agreement entered into under this section, and (B)[69] performance of such functions with respect to specific providers of services, and the Secretary shall establish standards and criteria with respect to the efficient and effective administration of this part. No agency or organization shall be found under such standards and criteria not to be efficient or effective or to be less efficient or effective solely on the ground that the agency or organization serves only providers located in a single State.[70]

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[67] P.L. 101-508, §4005(c)(1)(A)(ii), redesignated (f) as (f)(1), effective November 5, 1990.

[68] P.L. 101-508, §4005(c)(1)(A)(i), struck out "(1)" and substituted "(A)", effective November 5, 1990.

[69] P.L. 101-508, §4005(c)(1)(A)(i), struck out "(2)" and substituted "(B)", effective November 5, 1990.

(2) The standards and criteria established under paragraph (1) shall include—

(A) with respect to claims for services furnished under this part by any provider of services other than a hospital—

(i) whether such agency or organization is able to process 75 percent of reconsiderations within 60 days (except in the case of fiscal year 1989, 66 percent of reconsiderations) and 90 percent of reconsiderations within 90 days, and

(ii) the extent to which such agency[71] or organization's determinations are reversed on appeal; and

(B) with respect to applications for an exemption from or exception or adjustment to the target amount applicable under section 1886(b) to a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B))—

(i) if such agency or organization receives a completed application, whether such agency or organization is able to process such application not later than 75 days after the application is filed, and

(ii) if such agency or organization receives an incomplete application, whether such agency or organization is able to return the application with instructions on how to complete the application not later than 60 days after the application is filed.[72]

(g) An agreement with the Secretary under this section may be terminated—

(1) by the agency or organization which entered into such agreement at such time and upon such notice to the Secretary, to the public, and to the providers as may be provided in regulations, or

(2) by the Secretary at such time and upon such notice to the agency or organization, to the providers which have nominated it for purposes of this section, and to the public, as may be provided in regulations, but only if he finds, after applying the standards, criteria, and procedures developed under subsection (f) and after reasonable notice and opportunity for hearing to the agency or organization, that (A) the agency or organization has failed substantially to carry out the agreement, or (B) the continuation of some or all of the functions provided for in the agreement with the agency or organization is disadvantageous or is inconsistent with the efficient administration of this part.

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[70] P.L. 101-508, §4005(c)(1)(A)(iii), struck out "Such standards and criteria shall be published in the Federal Register, and opportunity shall be provided for public comment prior to implementation. Such standards and criteria shall include with respect to claims for services furnished under this part by any provider of services other than a hospital whether such agency or organization is able to process 75 percent of reconsiderations within 60 days (except in the case of the fiscal year 1989, 66 percent of reconsiderations) and 90 percent of reconsiderations within 90 days and the extent to which its determinations are reversed on appeal.", and substituted paragraph (2), effective November 5, 1990.

[71] Probably should be "agency's".

[72] P.L. 101-508, §4005(c)(1)(A)(iii), added paragraph (2), effective November 5, 1990.

(h) An agreement with an agency or organization under this section may require any of its officers or employees certifying payments or disbursing funds pursuant to the agreement, or otherwise participating in carrying out the agreement, to give surety bond to the United States in such amount as the Secretary may deem appropriate.[73]

(i)(1) No individual designated pursuant to an agreement under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

(3) No such agency or organization shall be liable to the United States for any payments referred to in paragraph (1) or (2).

(j) An agreement with an agency or organization under this section shall require that, with respect to a claim for home health services, extended care services, or post-hospital extended care services submitted by a provider to such agency or organization that is denied, such agency or organization—

(1) furnish the provider and the individual with respect to whom the claim is made with a written explanation of the denial and of the statutory or regulatory basis for the denial; and

(2) in the case of a request for reconsideration of a denial, promptly notify such individual and the provider of the disposition of such reconsideration.

[(k) Repealed.[74]]

FEDERAL HOSPITAL INSURANCE TRUST FUND[75]

SEC. 1817. [42 U.S.C. 1395i] (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Hospital Insurance Trust Fund" (hereinafter in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. There are hereby appropriated to the Trust Fund for the fiscal year ending June 30, 1966, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) the taxes imposed by sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954[76] with respect to wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of such Code[77] after December 31, 1965, as determined

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[73] See Vol. II, 31 U.S.C. 9309 with respect to priority of sureties.

[74] P.L. 101-234, §201(a)(1), repealed subsection (k), effective January 1, 1990. [For subsection (k) as it formerly read, see Vol. III, P.L. 101-234.]

[75] See Vol. II, P.L. 89-97, §103(c), for the transitional provision for uninsured individuals.

See Vol. II, P.L. 99-509, §9305(k), with respect to the prior and concurrent authorization demonstration project.

[76] See P.L. 83-591, §3101(b) (this volume).

[77] P.L. 83-591.

P.L. 99-514, §2, provides, except when inappropriate, any reference to the Internal Revenue Code of 1954 shall include a reference to the Internal Revenue Code of 1986.

by the Secretary of the Treasury by applying the applicable rates of tax under such sections to such wages, which wages shall be certified by the Secretary of Health and Human Services on the basis of records of wages established and maintained by the Secretary of Health and Human Services in accordance with such reports; and

(2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1954[78] with respect to self-employment income reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such self-employment income, which self-employment income shall be certified by the Secretary of Health and Human Services on the basis of records of self-employment established and maintained by the Secretary of Health and Human Services in accordance with such returns.

The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such sentence.

(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the "Managing Trustee"). The Administrator of the Health Care Financing Administration shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Fund;

(2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years;

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[78] See P.L. 83-591, §1401(b) (this volume).

(3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

(4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund.[79] Such report shall also include an actuarial opinion by the Chief Actuarial Officer of the Health Care Financing Administration certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable. Such report shall be printed as a House document of the session of the Congress to which the report is made. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

(c) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31, United States Code, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.[80]

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[79] P.L. 101-234, §202(a), struck out "Such report shall also identify (and treat separately) those outlays from the Trust Fund which are also outlays from the Medicare Catastrophic Coverage Account created under section 1841B and those outlays for which there are amounts transferred into the Federal Hospital Insurance Catastrophic Coverage Reserve Fund.", effective January 1, 1990.

[80] See Vol. II, P.L. 100-203, §9401, with respect to the restoration of trust funds for 1987.

(d) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(e) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(f)(1) The Managing Trustee is directed to pay from time to time from the Trust Fund into the Treasury the amount estimated by him as taxes imposed under section 3101(b) which are subject to refund under section 6413(c) of the Internal Revenue Code of 1954[81] with respect to wages paid after December 31, 1965. Such taxes shall be determined on the basis of the records of wages established and maintained by the Secretary of Health and Human Services in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954[82], and the Secretary of Health and Human Services shall furnish the Managing Trustee such information as may be required by the Managing Trustee for such purpose. The payments by the Managing Trustee shall be covered into the Treasury as repayments to the account for refunding internal revenue collections.

(2) Repayments made under paragraph (1) shall not be available for expenditures but shall be carried to the surplus fund of the Treasury. If it subsequently appears that the estimates under such paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Managing Trustee in future payments.

(g) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health and Human Services shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1870(b) of this Act. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the Secretary of Health and Human Services shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1870(b) of this Act.

(h) The Managing Trustee shall also pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g)(1).

(i) There are authorized to be made available for expenditure out of the Trust Fund such amounts as are required to pay travel expenses, either on an actual cost or commuted basis, to parties, their representatives, and all reasonably necessary witnesses for travel within the United States (as defined in section 210(i)) to attend reconsideration interviews and proceedings before administrative law judges with respect to any determination under this title. The amount available under the preceding sentence for payment for air travel by any person shall not exceed the coach fare for air travel between the points involved unless the use of first-class accommodations is required (as determined under regulations of the Secretary) because of such person's health condition or the unavailability of alternative accommodations; and the amount available for payment for other travel by any person shall not exceed the cost of travel (between the points involved) by the most economical and expeditious means of transportation appropriate to such person's health condition, as specified in such regulations. The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount allowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding.[83]

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[81] See P.L. 83-591, §3101(b) (this volume).

[82] P.L. 83-591.

(j)(1) If at any time prior to January 1988 the Managing Trustee determines that borrowing authorized under this subsection is appropriate in order to best meet the need for financing the benefit payments from the Federal Hospital Insurance Trust Fund, the Managing Trustee may, subject to paragraph (5), borrow such amounts as he determines to be appropriate from either the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund for transfer to and deposit in the Federal Hospital Insurance Trust Fund.

(2) In any case where a loan has been made to the Federal Hospital Insurance Trust Fund under paragraph (1), there shall be transferred on the last day of each month after such loan is made, from such Trust Fund to the lending Trust Fund, the total interest accrued to such day with respect to the unrepaid balance of such loan at a rate equal to the rate which the lending Trust Fund would earn on the amount involved if the loan were an investment under subsection (c) (even if such an investment would earn interest at a rate different than the rate earned by investments redeemed by the lending fund in order to make the loan).

(3)(A) If in any month after a loan has been made to the Federal Hospital Insurance Trust Fund under paragraph (1), the Managing Trustee determines that the assets of such Trust Fund are sufficient to permit repayment of all or part of any loans made to such Fund under paragraph (1), he shall make such repayments as he determines to be appropriate.

(B)(i) If on the last day of any year after a loan has been made under paragraph (1) by the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund to the Federal Hospital Insurance Trust Fund, the Managing Trustee determines that the Hospital Insurance Trust Fund ratio exceeds 15 percent, he shall transfer from such Trust Fund to the lending trust fund an amount that—

(I) together with any amounts transferred to another lending trust fund under this paragraph for such year, will reduce the Hospital Insurance Trust Fund ratio to 15 percent; and

(II) does not exceed the outstanding balance of such loan.

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[83] P.L. 101-508, §5106(c), added this sentence, applicable with respect to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after April 1, 1991.

(ii) Amounts required to be transferred under clause (i) shall be transferred on the last day of the first month of the year succeeding the year in which the determination described in clause (i) is made.

(iii) For purposes of this subparagraph, the term "Hospital Insurance Trust Fund ratio" means, with respect to any calendar year, the ratio of—

(I) the balance in the Federal Hospital Insurance Trust Fund, as of the last day of such calendar year; to

(II) the amount estimated by the Secretary to be the total amount to be paid from the Federal Hospital Insurance Trust Fund during the calendar year following such calendar year (other than payments of interest on, and repayments of, loans from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund under paragraph (1)), and reducing the amount of any transfer to the Railroad Retirement Account by the amount of any transfers into such Trust Fund from the Railroad Retirement Account.

(C)(i) The full amount of all loans made under paragraph (1) (whether made before or after January 1, 1983) shall be repaid at the earliest feasible date and in any event no later than December 31, 1989.

(ii) For the period after December 31, 1987 and before January 1, 1990, the Managing Trustee shall transfer each month from the Federal Hospital Insurance Trust Fund to any Trust Fund that is owed any amount by the Federal Hospital Insurance Trust Fund on a loan made under paragraph (1), an amount not less than an amount equal to (I) the amount owed to such Trust Fund by the Federal Hospital Insurance Trust Fund at the beginning of such month (plus the interest accrued on the outstanding balance of such loan during such month), divided by (II) the number of months elapsing after the preceding month and before January 1990. The Managing Trustee may, during this period, transfer larger amounts than prescribed by the preceding sentence.

(4) The Board of Trustees shall make a timely report to the Congress of any amounts transferred (including interest payments) under this subsection.

(5)(A) No amounts may be loaned by the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund under paragraph (1) during any month if the OASDI trust fund ratio for such month is less than 10 percent.

(B) For purposes of this paragraph, the term "OASDI trust fund ratio" means, with respect to any month, the ratio of—

(i) the combined balance in the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, reduced by the outstanding amount of any loan (including interest thereon) theretofore made to either such Trust Fund from the Federal Hospital Insurance Trust Fund under section 201(l), as of the last day of the second month preceding such month, to

(ii) the amount obtained by multiplying by twelve the total amount which (as estimated by the Secretary) will be paid from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund during the month for which such ratio is to be determined for all purposes authorized by section 201 (other than payments of interest on, or repayments of, loans from the Federal Hospital Insurance Trust Fund under section 201(l)), but excluding any transfer payments between such trust funds and reducing the amount of any transfers to the Railroad Retirement Account by the amount of any transfers into either such trust fund from that Account.

[SEC. 1817A. Repealed.[84]]

HOSPITAL INSURANCE BENEFITS FOR UNINSURED ELDERLY[85] INDIVIDUALS NOT OTHERWISE ELIGIBLE

SEC. 1818. [42 U.S.C. 1395i-2] (a) Every individual who—

(1) has attained the age of 65,

(2) is enrolled under part B of this title,

(3) is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this section, and

(4) is not otherwise entitled to benefits under this part,

shall be eligible to enroll in the insurance program established by this part.

(b) An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.

(c) The provisions of section 1837 (except subsection (f) thereof), section 1838, subsection (b) of section 1839, and subsections (f) and (h) of section 1840 shall apply to persons authorized to enroll under this section except that—

(1) individuals who meet the conditions of subsection (a)(1), (3), and (4) on or before the last day of the seventh month after the month in which this section is enacted[86] may enroll under this part and (if not already so enrolled) may also enroll under part B during an initial general enrollment period which shall begin on the first day of the second month which begins after the date on which this section is enacted and shall end on the last day of the tenth month after the month in which this section is enacted;

(2) in the case of an individual who first meets the conditions of eligibility under this section on or after the first day of the eighth month after the month in which this section is enacted, the initial enrollment period shall begin on the first day of the third month before the month in which he first becomes eligible and shall end 7 months later;

(3) in the case of an individual who enrolls pursuant to paragraph (1) of this subsection, entitlement to benefits shall begin on—

(A) the first day of the second month after the month in which he enrolls,

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[84] P.L. 101-234, §102(a), repealed §1817A, effective January 1, 1990. [For §1817A as if formerly read, see Vol. III, P.L. 101-234.]

See Vol. II, P.L. 100-360, §113, [as amended by P.L. 101-234, §102(b)], with respect to the study of tax incentives for purchase of coverage for long-term care.

See Vol. II, P.L. 101-234, §102(c), with respect to the disposal of funds in the Federal Hospital Insurance Catastrophic Coverage Reserve Fund.

[85] P.L. 101-239, §6012(a)(1), inserted "ELDERLY", effective December 19, 1989, but shall not apply so as to provide for coverage under part A of this title for any month before July 1990.

[86] October 30, 1972 [P.L. 92-603; 86 Stat. 1374].

(B) July 1, 1973, or

(C) the first day of the first month in which he meets the requirements of subsection (a),

whichever is the latest;

(4) an individual's entitlement under this section shall terminate with the month before the first month in which he becomes eligible for hospital insurance benefits under section 226 of this Act or section 103 of the Social Security Amendments of 1965[87]; and upon such termination, such individual shall be deemed, solely for purposes of hospital insurance entitlement, to have filed in such first month the application required to establish such entitlement;

(5) termination of coverage for supplementary medical insurance shall result in simultaneous termination of hospital insurance benefits for uninsured individuals who are not otherwise entitled to benefits under this Act;[88]

(6) any percent increase effected under section 1839(b) in an individual's monthly premium may not exceed 10 percent and shall only apply to premiums paid during a period equal to twice the number of months in the full 12-month periods described in that section;[89]

(7) an individual who meets the conditions of subsection (a) may enroll under this part during a special enrollment period that includes any month during any part of which the individual is enrolled under section 1876 with an eligible organization and ending with the last day of the 8th consecutive month in which the individual is at no time so enrolled;[90]

(8) in the case of an individual who enrolls during a special enrollment period under paragraph (7)—

(A) in any month of the special enrollment period in which the individual is at any time enrolled under section 1876 with an eligible organization or in the first month following such a month, the coverage period shall begin on the first day of the month in which the individual so enrolls (or, at the option of the individual, on the first day of any of the following three months), or

(B) in any other month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls; and[91]

(9) in applying the provisions of section 1839(b), there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled under section 1876 with an eligible organization.[92]

(d)(1) The Secretary shall, during September of each year (beginning with 1988), estimate the monthly actuarial rate for months in the succeeding year. Such actuarial rate shall be one-twelfth of the amount which the Secretary estimates (on an average, per capita basis) is equal to 100 percent of the benefits and administrative costs which will be payable from the Federal Hospital Insurance Trust

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[87] P.L. 89-97.

[88] P.L. 101-508, §4008(g)(1)(A), struck out "and".

[89] P.L. 101-508, §4008(g)(1)(B), struck out a period and substituted a semicolon.

[90] P.L. 101-508, §4008(g)(1)(C), added paragraph (7), effective February 1, 1991.

[91] P.L. 101-508, §4008(g)(1)(C), added paragraph (8), effective February 1, 1991.

[92] P.L. 101-508, §4008(g)(1)(C), added paragraph (9), effective February 1, 1991.

Fund for services performed and related administrative costs incurred in the succeeding year with respect to individuals age 65 and over who will be entitled to benefits under this part during that[93] year.

(2) The Secretary shall, during September of each year determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in the following year. Such amount shall be equal to the monthly actuarial rate determined under paragraph (1) for that following year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(3) Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium under this section, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for individuals 65 and older as provided in paragraph (1).

(e) Payment of the monthly premiums on behalf of any individual who meets the conditions of subsection (a) may be made by any public or private agency or organization under a contract or other arrangement entered into between it and the Secretary if the Secretary determines that payment of such premiums under such contract or arrangement is administratively feasible.

(f) Amounts paid to the Secretary for coverage under this section shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

(g)(1) The Secretary shall, at the request of a State made after 1989, enter into a modification of an agreement entered into with the State pursuant to section 1843(a) under which the agreement provides for enrollment in the program established by this part of qualified medicare beneficiaries (as defined in section 1905(p)(1)).

(2)(A) Except as provided in subparagraph (B), the provisions of subsections (c), (d), (e), and (f) of section 1843 shall apply to qualified medicare beneficiaries enrolled, pursuant to such agreement, in the program established by this part in the same manner and to the same extent as they apply to qualified medicare beneficiaries enrolled, pursuant to such agreement, in part B.

(B) For purposes of this subsection, section 1843(d)(1) shall be applied by substituting "section 1818" for "section 1839" and "subsection (c)(6)[94] (with reference to subsection (b) of section 1839)" for "subsection (b).".[95]

HOSPITAL INSURANCE BENEFITS FOR DISABLED INDIVIDUALS WHO HAVE EXHAUSTED OTHER ENTITLEMENT[96]

SEC. 1818A. [42 U.S.C. 1395i-2a] (a) Every individual who—

(1) has not attained the age of 65;

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[93] P.L. 100-485, §608(d)(2), struck out "entire", effective as if included in the enactment of P.L. 100-360.

[94] P.L. 101-508, §4008(m)(3)(D), inserted "(6)", effective November 5, 1990.

[95] P.L. 101-239, §6013(a), added this subsection, effective January 1, 1990.

[96] P.L. 101-239, §6012(a)(2), added §1818A, effective December 19, 1989, but shall not apply so as to provide for coverage under part A of this title for any month before July 1990.

(2)(A) has been entitled to benefits under this part under section 226(b), and

(B)(i) continues to have the disabling physical or mental impairment on the basis of which the individual was found to be under a disability or to be a disabled qualified railroad retirement beneficiary, or (ii) is blind (within the meaning of section 216(i)(1)), but

(C) whose entitlement under section 226(b) ends due solely to the individual having earnings that exceed the substantial gainful activity amount (as defined in section 223(d)(4)); and

(3) is not otherwise entitled to benefits under this part,

shall be eligible to enroll in the insurance program established by this part.

(b)(1) An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.

(2) The individual's initial enrollment period shall begin with the month in which the individual receives notice that the individual's entitlement to benefits under section 226(b) will end due solely to the individual having earnings that exceed the substantial gainful activity amount (as defined in section 223(d)(4)) and shall end 7 months later.

(3) There shall be a general enrollment period during the period beginning on January 1 and ending on March 31 of each year (begining with 1990).

(c)(1) The period (in this subsection referred to as a "coverage period") during which an individual is entitled to benefits under the insurance program under this part shall begin on whichever of the following is the latest:

(A) In the case of an individual who enrolls under subsection (b)(2) before the month in which the individual first satisfies subsection (a), the first day of such month.

(B) In the case of an individual who enrolls under subsection (b)(2) in the month in which the individual first satisfies subsection (a), the first day of the month following the month in which the individual so enrolls.

(C) In the case of an individual who enrolls under subsection (b)(2) in the month following the month in which the individual first satisfies subsection (a), the first day of the second month following the month in which the individual so enrolls.

(D) In the case of an individual who enrolls under subsection (b)(2) more than one month following the month in which the individual first satisfies subsection (a), the first day of the third month following the month in which the individual so enrolls.

(E) In the case of an individual who enrolls under subsection (b)(3), the July 1 following the month in which the individual so enrolls.

(2) An individual's coverage period under this section shall continue until the individual's enrollment is terminated as follows:

(A) As of the month following the month in which the Secretary provides notice to the individual that the individual no longer meets the condition described in subsection (a)(2)(B).

(B) As of the month following the month in which the individual files notice that the individual no longer wishes to participate in the insurance program established by this part.

(C) As of the month before the first month in which the individual becomes eligible for hospital insurance benefits under section 226(a) or 226A.

(D) As of a date, determined under regulations of the Secretary, for nonpayment of premiums.

The regulations under subparagraph (D) may provide a grace period of not longer than 90 days, which may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period. Termination of coverage under this section shall result in simultaneous termination of any coverage affected under any other part of this title.

(3) The provisions of subsections (h) and (i) of section 1837 apply to enrollment and nonenrollment under this section in the same manner as they apply to enrollment and nonenrollment and special enrollment periods under section 1818.

(d)(1)(A) Premiums for enrollment under this section[97] shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe, and shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

(B)(i) Subject to clause (ii), such premiums shall be payable for the period commencing with the first month of an individual's coverage period and ending with the month in which the individual dies or, if earlier, in which the individual's coverage period terminates.

(ii) Such premiums shall not be payable for any month in which the individual is eligible for benefits under this part pursuant to section 226(b).[98]

(2) The provisions of subsections (d) through (f) of section 1818 (relating to premiums) shall apply to individuals enrolled under this section in the same manner as they apply to individuals enrolled under that section.

REQUIREMENTS FOR, AND ASSURING QUALITY OF CARE IN, SKILLED NURSING FACILITIES[99]

SEC. 1819. [42 U.S.C. 1395i-3] (a) SKILLED NURSING FACILITY DEFINED.—In this title, the term "skilled nursing facility" means an institution (or a distinct part of an institution) which—

(1) is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care, or

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons,

and is not primarily for the care and treatment of mental diseases;

(2) has in effect a transfer agreement (meeting the requirements of section 1861(l)) with one or more hospitals having agreements in effect under section 1866; and

(3) meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of this section.

(b) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—

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[97] P.L. 101-508, §4008(m)(3)(C)(i), inserted "for enrollment under this section", effective November 5, 1990.

[98] P.L. 101-508, §4008(m)(3)(C)(ii), struck out subparagraph (C), effective November 5, 1990. [For subparagraph (C) as it formerly read, see Vol. III, P.L. 101-508.]

[99] P.L. 100-203, §4201(a)(3), added §1819. For the effective date, see Vol. II, P.L. 100-203, §4204(a). See Vol. II, P.L. 100-203, §4205, with respect to the annual report to Congress.

(1) QUALITY OF LIFE.—

(A) IN GENERAL.—A skilled nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(B) QUALITY ASSESSMENT AND ASSURANCE.—A skilled nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.[100]

(2) SCOPE OF SERVICES AND ACTIVITIES UNDER PLAN OF CARE.—A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care which—

(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

(3) RESIDENTS' ASSESSMENT.—

(A) REQUIREMENT.—A skilled nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);

(iii) uses an instrument which is specified by the State under subsection (e)(5); and

(iv) includes the identification of medical problems.

(B) CERTIFICATION.—

(i) IN GENERAL.—Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

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[100] P.L. 101-508, §4008(h)(2)(B), added this sentence, effective as if included in the enactment of P.L. 100-203.

(ii) PENALTY FOR FALSIFICATION.—

(I) An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 with respect to each assessment.

(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 with respect to each assessment.

(III) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(iii) USE OF INDEPENDENT ASSESSORS.—If a State determines, under a survey under subsection (g) or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(C) FREQUENCY.—

(i) IN GENERAL.—Such an assessment must be conducted—

(I) promptly upon (but no later than not later than 14 days[101] after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than January 1, 1991, for each resident of the facility on that date;

(II) promptly after a significant change in the resident's physical or mental condition; and

(III) in no case less often than once every 12 months.

(ii) RESIDENT REVIEW.—The skilled nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

(D) USE.—The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

(E) COORDINATION.—Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort.

(4) PROVISION OF SERVICES AND ACTIVITIES.—

(A) IN GENERAL.—To the extent needed to fulfill all plans of care described in paragraph (2), a skilled nursing facility must provide, directly or under arrangements (or, with respect to dental services, under agreements) with others for the provision of—

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[101] P.L. 101-508, §4008(h)(2)(C), struck out "4 days" and substituted "not later than 14 days", effective as if included in the enactment of P.L. 100-203. Probably should also have struck out "no later than".

(i) nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident;[102]

(vi) routine and emergency dental services to meet the needs of each resident; and[103]

(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.[104]

The services provided or arranged by the facility must meet professional standards of quality. Nothing in clause (vi) shall be construed as requiring a facility to provide or arrange for dental services described in that clause without additional charge.[105]

(B) QUALIFIED PERSONS PROVIDING SERVICES.—Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

(C) REQUIRED NURSING CARE.—

(i) IN GENERAL.—Except as provided in clause (ii), a skilled nursing facility must provide 24-hour licensed nursing service which is sufficient to meet nursing needs of its residents and must use the services of a registered professional nurse at least at least[106] 8 consecutive hours a day, 7 days a week.

(ii) EXCEPTION.—To the extent that clause (i) may be deemed to require that a skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if the Secretary finds that—

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[102] P.L. 101-508, §4008(h)(2)(D)(i), struck out "and", effective as if included in the enactment of P.L. 100-203.

[103] P.L. 101-508, §4008(h)(2)(D)(ii), struck out a period and substituted "; and", effective as if included in the enactment of P.L. 100-203.

[104] P.L. 101-508, §4008(h)(2)(D)(iii), added clause (vii), effective as if included in the enactment of P.L. 100-203.

[105] See Vol. II, P.L. 101-508, §4008(h)(2)(O) and (P), with respect to maintaining regulatory standards for certain services.

[106] Second "at least" should be stricken.

(I) the facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,

(II) the facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week,[107]

(III) the facility either has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty,[108]

(IV) the Secretary provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965[109]) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and[110]

(V) the facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.[111]

A waiver under this subparagraph shall be subject to annual renewal.

(5) REQUIRED TRAINING OF NURSE AIDES.—

(A) IN GENERAL.—(i) Except as provided in clause (ii), a[112] skilled nursing facility must not use on a full-time basis[113] any individual as a nurse aide in the facility on or after October[114] 1, 1990 for more than 4 months unless the individual—

(I)[115] has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A), and

(II)[116] is competent to provide nursing or nursing-related services.[117]

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[107] P.L. 101-508, §4008(h)(2)(E)(i), struck out "and", effective as if included in the enactment of P.L. 100-203.

[108] P.L. 101-508, §4008(h)(2)(E)(ii), struck out a period and substituted a comma, effective as if included in the enactment of P.L. 100-203.

[109] P.L. 89-73.

[110] P.L. 101-508, §4008(h)(2)(E)(iii), added subclause (IV), effective as if included in the enactment of P.L. 100-203.

[111] P.L. 101-508, §4008(h)(2)(E)(iii), added subclause (V), effective as if included in the enactment of P.L. 100-203.

[112] P.L. 101-508, §4008(h)(1)(B)(i), struck out "A" and substituted "(i) Except as provided in clause (ii), a", effective as if included in the enactment of P.L. 100-203.

[113] P.L. 101-508, §4008(h)(1)(B)(ii), struck out "(on a full-time, temporary, per diem, or other basis)" and substituted "on a full-time basis", effective as if included in the enactment of P.L. 100-203.

[114] P.L. 101-239, §6901(b)(1)(A), struck out "January" and substituted "October", effective as if included in the enactment of P.L. 100-203.

[115] P.L. 101-508, §4008(h)(1)(B)(iii), redesignated clause (i) as subclause (I), effective as if included in the enactment of P.L. 100-203.

[116] P.L. 101-508, §4008(h)(1)(B)(iii), redesignated clause (ii) as subclause (II), effective as if included in the enactment of P.L. 100-203.

(ii) A skilled nursing facility must not use on a temporary, per diem, leased, or on any basis other than as a permanent employee any individual as a nurse aide in the facility on or after January 1, 1991, unless the individual meets the requirements described in clause (i).[118]

(B) Offering competency evaluation programs for current employees.—A skilled nursing facility must provide, for individuals used as a nurse aide by the facility as of January 1, 1990[119], for a competency evaluation program approved by the State under subsection (e)(1) and such preparation as may be necessary for the individual to complete such a program by October[120] 1, 1990.

(C) Competency.—The skilled nursing facility must not permit an individual, other than in a training and competency evaluation program[121] approved by the State, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use such an individual as a nurse aide unless the facility has inquired of any State registry established under subsection (e)(2)(A) that the facility believes will include information[122] concerning the individual.

(D) Re-training required.—For purposes of subparagraph (A), if, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual shall complete a new training and competency evaluation program, or a new competency evaluation program[123].

(E) Regular in-service education.—The skilled nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments.

(F) Nurse aide defined.—In this paragraph, the term "nurse aide" means any individual providing nursing or nursing-related services to residents in a skilled nursing facility, but does not include an individual—

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[117] See Vol. II, P.L. 101-239, §6901(b)(4)(B)-(D), with respect to satisfying the requirement of this subparagraph.

[118] P.L. 101-508, §4008(h)(1)(B)(iv), added clause (ii), effective as if included in the enactment of P.L. 100-203. Margin as in original.

[119] P.L. 101-239, §6901(b)(1)(B), struck out "July 1, 1989" and substituted "January 1, 1990", effective as if included in the enactment of P.L. 100-203.

[120] P.L. 101-239, §6901(b)(1)(B), struck out "January" and substituted "October", effective as if included in the enactment of P.L. 100-203.

[121] As in original.

[122] P.L. 101-508, §4008(h)(1)(C), struck out "the State registry established under subsection (e)(2)(A) as to information in the registry" and substituted "any State registry established under subsection (e)(2)(A) that the facility believes will include information", effective as if included in the enactment of P.L. 100-203.

[123] P.L. 101-508, §4008(h)(1)(D), inserted ", or a new competency evaluation program", effective as if included in the enactment of P.L. 100-203.

(i) who is a licensed health professional (as defined in subparagraph (G)) or a registered dietician[124], or

(ii) who volunteers to provide such services without monetary compensation.

(G) LICENSED HEALTH PROFESSIONAL DEFINED.—In this paragraph, the term "licensed health professional" means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

(6) PHYSICIAN SUPERVISION AND CLINICAL RECORDS.—A skilled nursing facility must—

(A) require that the medical care of every resident be provided under the supervision of a physician;

(B) provide for having a physician available to furnish necessary medical care in case of emergency; and

(C) maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)).

(7) REQUIRED SOCIAL SERVICES.—In the case of a skilled nursing facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

(c) REQUIREMENTS RELATING TO RESIDENTS' RIGHTS.—

(1) GENERAL RIGHTS.—

(A) SPECIFIED RIGHTS.—A skilled nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) FREE CHOICE.—The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(ii) FREE FROM RESTRAINTS.—The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained)[125].

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[124] P.L. 101-508, §4008(h)(2)(F), inserted "or a registered dietician", effective as if included in the enactment of P.L. 100-203.

[125] P.L. 101-239, §6901(d)(4)(A), struck out "Secretary) until such an order could reasonably be obtained" and substituted "Secretary until such an order could reasonably be obtained)", effective as if included in the enactment of P.L. 100-203.

(iii) PRIVACY.—The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

(iv) CONFIDENTIALITY.—The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request[126].

(v) ACCOMMODATION OF NEEDS.—The right—

(I) to reside and receive services with reasonable accommodation[127] of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

(II) to receive notice before the room or roommate of the resident in the facility is changed.

(vi) GRIEVANCES.—The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(vii) PARTICIPATION IN RESIDENT AND FAMILY GROUPS.—The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

(viii) PARTICIPATION IN OTHER ACTIVITIES.—The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(ix) EXAMINATION OF SURVEY RESULTS.—The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

(x) REFUSAL OF CERTAIN TRANSFERS.—The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is a skilled nursing facility (for purposes of this title) to a portion of the facility that is not such a skilled nursing facility.[128]

(xi)[129] OTHER RIGHTS.—Any other right established by the Secretary.

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[126] P.L 101-508, §4008(h)(2)(H), inserted "and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request", effective as if included in the enactment of P.L. 100-203.

[127] P.L. 101-239, §6901(d)(4)(B), struck out "accommodations" and substituted "accommodation", effective as if included in the enactment of P.L. 100-203.

[128] P.L. 101-508, §4008(h)(2)(G)(i), inserted this clause (x), effective as if included in the enactment of P.L. 100-203.

[129] P.L. 101-508, §4008(h)(2)(G)(i), redesignated the former clause (x) as clause (xi), effective as if included in the enactment of P.L. 100-203.

Clause (iii) shall not be construed as requiring the provision of a private room. A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to benefits under this title or to medical assistance under title XIX of this Act.[130]

(B) NOTICE OF RIGHTS AND SERVICES.—A skilled nursing facility must—

(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility;

(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights) including the notice (if any) of the State developed under section 1919(e)(6)[131]; and

(iii) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under this title or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and a statement that a resident may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

(C) RIGHTS OF INCOMPETENT RESIDENTS.—In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this title shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

(D) USE OF PSYCHOPHARMACOLOGIC DRUGS.—Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs.

(E) INFORMATION RESPECTING ADVANCE DIRECTIVES.—A skilled nursing facility must comply with the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).[132]

(2) TRANSFER AND DISCHARGE RIGHTS.—

(A) IN GENERAL.—A skilled nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless—

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[130] P.L. 101-508, §4008(h)(2)(G)(B)(sic), added this sentence, effective as if included in the enactment of P.L. 100-203.

[131] P.L. 101-508, §4008(h)(2)(I), inserted "including the notice (if any) of the State developed under section 1919(e)(6)", effective as if included in the enactment of P.L. 100-203.

[132] P.L. 101-508, §4206(d)(1), added subparagraph (E), applicable with respect to services furnished on or after December 1, 1991.

(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) the safety of individuals in the facility is endangered;

(iv) the health of individuals in the facility would otherwise be endangered;

(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this title or title XIX on the resident's behalf) for a stay at the facility; or

(vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (v), the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the cases described in clauses (iii) and (iv) the documentation must be made by a physician.

(B) PRE-TRANSFER AND PRE-DISCHARGE NOTICE.—

(i) IN GENERAL.—Before effecting a transfer or discharge of a resident, a skilled nursing facility must—

(I) notify the resident (and, if known, a family member of the resident or legal representative) of the transfer or discharge and the reasons therefor,

(II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

(III) include in the notice the items described in clause (iii).

(ii) TIMING OF NOTICE.—The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except—

(I) in a case described in clause (iii) or (iv) of subparagraph (A);

(II) in a case described in clause (ii) of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge;

(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

(IV) in a case where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

(iii) ITEMS INCLUDED IN NOTICE.—Each notice under clause (i) must include—

(I) for transfers or discharges effected on or after October 1, 1990, notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (e)(3); and

(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965[133]).

(C) ORIENTATION.—A skilled nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(3) ACCESS AND VISITATION RIGHTS.—A skilled nursing facility must—

(A) permit immediate access to any resident by any representative of the Secretary, by any representative of the State, by an ombudsman described in paragraph (2)(B)(iii)(II), or by the resident's individual physician;

(B) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives of the resident;

(C) permit immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident;

(D) permit reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

(E) permit representatives of the State ombudsman (described in paragraph (2)(B)(iii)(II)), with the permission of the resident (or the resident's legal representative) and consistent with State law, to examine a resident's clinical records.

(4) EQUAL ACCESS TO QUALITY CARE.—A skilled nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and covered services under this title for all individuals regardless of source of payment.

(5) ADMISSIONS POLICY.—

(A) ADMISSIONS.—With respect to admissions practices, a skilled nursing facility must—

(i)(I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this title or under a State plan under title XIX, (II) not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under this title or such a State plan, and (III) prominently display in the facility and provide to such individuals written information about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits; and

(ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility.

(B) CONSTRUCTION.—

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[133] P.L. 89-73.

(i) No PREEMPTION OF STRICTER STANDARDS.—Subparagraph (A) shall not be construed as preventing States or political subdivisions therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under this title with respect to admissions practices of skilled nursing facilities.

(ii) CONTRACTS WITH LEGAL REPRESENTATIVES.—Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

(6) PROTECTION OF RESIDENT FUNDS.—

(A) IN GENERAL.—The skilled nursing facility—

(i) may not require residents to deposit their personal funds with the facility, and

(ii) upon the written authorization of the resident, must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph.

(B) MANAGEMENT OF PERSONAL FUNDS.—Upon written authorization of a resident under subparagraph (A)(ii), the facility must manage and account for the personal funds of the resident deposited with the facility as follows:

(i) DEPOSIT.—The facility must deposit any amount of personal funds in excess of $50 with respect to a resident in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the facility must maintain such funds in a non-interest bearing account or petty cash fund.

(ii) ACCOUNTING AND RECORDS.—The facility must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record.

(iii) CONVEYANCE UPON DEATH.—Upon the death of a resident with such an account, the facility must convey promptly the resident's personal funds (and a final accounting of such funds) to the individual administering the resident's estate.

(C) ASSURANCE OF FINANCIAL SECURITY.—The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(D) LIMITATION ON CHARGES TO PERSONAL FUNDS.—The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under this title or title XIX.

(d) REQUIREMENTS RELATING TO ADMINISTRATION AND OTHER MATTERS.—

(1) ADMINISTRATION.—

(A) IN GENERAL.—A skilled nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical[134] mental, and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5)).

(B) REQUIRED NOTICES.—If a change occurs in—

(i) the persons with an ownership or control interest (as defined in section 1124(a)(3)) in the facility,

(ii) the persons who are officers, directors, agents, or managing employees (as defined in section 1126(b)) of the facility,

(iii) the corporation, association, or other company responsible for the management of the facility, or

(iv) the individual who is the administrator or director of nursing of the facility,

the skilled nursing facility must provide notice to the State agency responsible for the licensing of the facility, at the time of the change, of the change and of the identity of each new person, company, or individual described in the respective clause.

(C) SKILLED NURSING FACILITY ADMINISTRATOR.—The administrator of a skilled nursing facility must meet standards established by the Secretary under subsection (f)(4).

(2) LICENSING AND LIFE SAFETY CODE.—

(A) LICENSING.—A skilled nursing facility must be licensed under applicable State and local law.

(B) LIFE SAFETY CODE.—A skilled nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel, and

(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in skilled nursing facilities.

(3) SANITARY AND INFECTION CONTROL AND PHYSICAL ENVIRONMENT.—A skilled nursing facility must—

(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

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[134] As in original.

(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

(4) MISCELLANEOUS.—

(A) COMPLIANCE WITH FEDERAL, STATE, AND LOCAL LAWS AND PROFESSIONAL STANDARDS.—A skilled nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1124) and with accepted professional standards and principles which apply to professionals providing services in such a facility.

(B) OTHER.—A skilled nursing facility must meet such other requirements relating to the health, safety, and well-being of residents or relating to the physical facilities thereof as the Secretary may find necessary.

(e) STATE REQUIREMENTS RELATING TO SKILLED NURSING FACILITY REQUIREMENTS.—The requirements, referred to in section 1864(d), with respect to a State are as follows:

(1) SPECIFICATION AND REVIEW OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND OF NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—The State must—

(A) by not later than January 1, 1989, specify those training and competency evaluation programs, and those competency evaluation programs, that the State approves for purposes of subsection (b)(5) and that meet the requirements established under subsection (f)(2)[135], and

(B) by not later than January 1, 1990, provide for the review and reapproval of such programs, at a frequency and using a methodology consistent with the requirements established under subsection (f)(2)(A)(iii).

The failure of the Secretary to establish requirements under subsection (f)(2) shall not relieve any State of its responsibility under this paragraph.

(2) NURSE AIDE REGISTRY.—

(A) IN GENERAL.—By not later than January 1, 1989, the State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program, approved under paragraph (1) in the State, or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989[136].

(B) INFORMATION IN REGISTRY.—The registry under subparagraph (A) shall provide (in accordance with regulations of the Secretary) for the inclusion of specific documented findings by a State under subsection (g)(1)(C) of resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings. The State shall make available to the public information in the registry. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement.

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[135] P.L. 101-508, §4008(h)(2)(J), struck out "clause (i) or (ii) of subsection (f)(2)(A)" and substituted "subsection (f)(2)", effective as if included in the enactment of P.L. 100-203.

[136] P.L. 101-508, §4008(h)(2)(K)(i), inserted ", or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989[*]", effective as if included in the enactment of P.L. 100-203.

[*] P.L. 101-239.

(C) PROHIBITION AGAINST CHARGES.—A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).[137]

(3) STATE APPEALS PROCESS FOR TRANSFERS AND DISCHARGES.—The State, for transfers and discharges from skilled nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism for hearing appeals on transfers and discharges of residents of such facilities. Such mechanism must meet the guidelines established by the Secretary under subsection (f)(3); but the failure of the Secretary to establish such guidelines shall not relieve any State of its responsibility to provide for such a fair mechanism.

(4) SKILLED NURSING FACILITY ADMINISTRATOR STANDARDS.—By not later than January 1, 1990, the State must have implemented and enforced the skilled nursing facility administrator standards developed under subsection (f)(4) respecting the qualification of administrators of skilled nursing facilities.

(5) SPECIFICATION OF RESIDENT ASSESSMENT INSTRUMENT.—Effective July 1, 1990, the State shall specify the instrument to be used by nursing facilities in the State in complying with the requirement of subsection (b)(3)(A)(iii). Such instrument shall be—

(A) one of the instruments designated under subsection (f)(6)(B), or

(B) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary under subsection (f)(6)(A).

(f) RESPONSIBILITIES OF SECRETARY RELATING TO SKILLED NURSING FACILITY REQUIREMENTS.—

(1) GENERAL RESPONSIBILITY.—It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in skilled nursing facilities under this title, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

(2) REQUIREMENTS FOR NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND FOR NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—

(A) IN GENERAL.—For purposes of subsections (b)(5) and (e)(1)(A), the Secretary shall establish, by not later than September 1, 1988—

(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents,[138] basic restorative services, and residents' rights) and[139] content of the curriculum, (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

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[137] P.L. 101-508, §4008(h)(2)(K)(ii), added subparagraph (C), effective as if included in the enactment of P.L. 100-203.

(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents[140], basic restorative services, residents' rights, and procedures for determination of competency;[141]

(iii) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs; and[142]

(iv) requirements, under both such programs, that—

(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)),[143]

(II) prohibit the imposition on a nurse aide who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program[144] of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program, and[145]

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[138] P.L. 101-239, §6901(b)(3)(A), inserted "care of cognitively impaired residents,", applicable to nurse aide training and competency evaluation programs, and nurse aide competency evaluation programs, offered on or after March 19, 1990, but shall not affect competency evaluations conducted under programs offered before March 19, 1990.

[139] P.L. 101-239, §6901(d)(4)(C), struck out a comma and substituted "and", effective as if included in the enactment of P.L. 100-203.

[140] P.L. 101-239, §6901(b)(3)(B), struck out "cognitive, behavioral and social care" and substituted "recognition of mental health and social service needs, care of cognitively impaired residents", applicable to nurse aide training and competency evaluation programs, and nurse aide competency evaluation programs, offered on or after March 19, 1990, but shall not affect competency evaluations conducted under programs offered before March 19, 1990.

[141] P.L. 101-508, §4008(m)(3)(F), struck out "and".

[142] P.L. 101-239, §6901(b)(3)(C), struck out the period and substituted "; and".

[143] P.L. 101-508, §4008(h)(1)(E)(i), struck out "and".

[144] P.L. 101-508, §4008(h)(1)(E)(ii), inserted "who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program", effective as if included in the enactment of P.L. 100-203.

[145] P.L. 101-239, §6901(b)(3)(D), added clause (iv), applicable to nurse aide training and competency evaluation programs, and nurse aide competency evaluation programs, offered on or after March 19, 1990, but shall not affect competency evaluations conducted under programs offered before March 19, 1990.

P.L. 101-508, §4008(h)(1)(E)(iii), struck out a period and substituted ", and".

(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a prorata basis during the period in which the nurse aide is so employed.[146]

(B) APPROVAL OF CERTAIN PROGRAMS.—Such requirements—

(i) may permit approval of programs offered by or in facilities, as well as outside facilities (including employee organizations), and of programs in effect on the date of the enactment of this section[147];

(ii) shall permit a State to find that an individual who has completed (before July 1, 1989) a nurse aide training and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

(iii) shall prohibit approval of such a program—

(I) offered by or in a skilled nursing facility which, within the previous 2 years—

(a) has operated under a waiver under subsection (b)(4)(C)(ii)(II);

(b) has been subject to an extended (or partial extended) survey under subsection (g)(2)(B)(i) or section 1919(g)(2)(B)(i); or

(c) has been assessed a civil money penalty described in subsection (h)(2)(B)(ii) or section 1919(h)(2)(A)(ii) of not less than $5,000, or has been subject to a remedy described in clauses (i) or (iii) of subsection (h)(2)(B), subsection (h)(4), section 1919(h)(1)(B)(i), or in clauses (i), (iii), or (iv) of section 1919(h)(2)(A), or[148]

(II) offered by or in a skilled nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in skilled nursing facilities.

A State may not delegate (through subcontract or otherwise)[149] its responsibility under clause (iii)(II) to the skilled nursing facility.[150]

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[146] P.L. 101-508, §4008(h)(1)(E)(iv), added subclause (III), effective as if included in the enactment of P.L. 100-203.

[147] This section was enacted on December 22, 1987 [P.L. 100-203; 101 Stat. 1330-160].

[148] P.L. 101-508, §4008(h)(1)(F)(i), amended subclause (I) in its entirety.

See Vol. II, P.L. 101-508, §4008(h)(1)(F)(ii), for the effective date. [For subclause (I) as it formerly read, see Vol. III, P.L. 101-508.]

[149] P.L. 101-508, §4008(h)(1)(G), inserted "(through subcontract or otherwise)" in the second sentence of subparagraph (B), effective as if included in the enactment of P.L. 100-203.

That second sentence probably should be moved 2 ems to the left.

[150] P.L. 101-239, §6901(b)(2), requires the Secretary to issue proposed regulations to establish the requirements described in this paragraph by not later than March 19, 1990.

(3) FEDERAL GUIDELINES FOR STATE APPEALS PROCESS FOR TRANSFERS AND DISCHARGES.—For purposes of subsections (c)(2)(B)(iii)(I) and (e)(3), by not later than October 1, 1988, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(3) must meet to provide a fair mechanism for hearing appeals on transfers and discharges of residents from skilled nursing facilities.

(4) SECRETARIAL STANDARDS FOR QUALIFICATION OF ADMINISTRATORS.—For purposes of subsections (d)(1)(C) and (e)(4), the Secretary shall develop, by not later than March 1, 1989, standards to be applied in assuring the qualifications of administrators of skilled nursing facilities.

(5) CRITERIA FOR ADMINISTRATION.—The Secretary shall establish criteria for assessing a skilled nursing facility's compliance with the requirement of subsection (d)(1) with respect to—

(A) its governing body and management,

(B) agreements with hospitals regarding transfers of residents to and from the hospitals and to and from other skilled nursing facilities,

(C) disaster preparedness,

(D) direction of medical care by a physician,

(E) laboratory and radiological services,

(F) clinical records, and

(G) resident and advocate participation.

(6) SPECIFICATION OF RESIDENT ASSESSMENT DATA SET AND INSTRUMENTS.—The Secretary shall—

(A) not later than January 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3), and establish guidelines for utilization of the data set; and

(B) by not later than April 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii).

(7) LIST OF ITEMS AND SERVICES FURNISHED IN SKILLED NURSING FACILITIES NOT CHARGEABLE TO THE PERSONAL FUNDS OF A RESIDENT.—

(A) REGULATIONS REQUIRED.—Pursuant to the requirement of section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977[151], the Secretary shall issue regulations, on or before the first day of the seventh month to begin after the date of enactment of this section[152], that define those costs which may be charged to the personal funds of residents in skilled nursing facilities who are individuals receiving benefits under this part and those costs which are to be included in the reasonable cost (or other payment amount) under this title for extended care services.

(B) RULE IF FAILURE TO PUBLISH REGULATIONS.—If the Secretary does not issue the regulations under subparagraph (A) on or before the date required in such subparagraph, in the case of a resident of a skilled nursing facility who is eligible to receive benefits under this part, the costs which may not be charged to the personal funds of such resident (and for which payment is considered to be made under this title) shall include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.

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[151] P.L. 95-142.

[152] This section was enacted on December 22, 1987 [P.L. 100-203; 101 Stat. 1330-160].

(g) SURVEY AND CERTIFICATION PROCESS.—

(1) STATE AND FEDERAL RESPONSIBILITY.—

(A) IN GENERAL.—Pursuant to an agreement under section 1864, each State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of skilled nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d). The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State skilled nursing facilities with the requirements of such subsections.

(B) EDUCATIONAL PROGRAM.—Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of skilled nursing facilities in order to present current regulations, procedures, and policies under this section.

(C) INVESTIGATION OF ALLEGATIONS OF RESIDENT NEGLECT AND ABUSE AND MISAPPROPRIATION OF RESIDENT PROPERTY.—The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority. A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.[153]

(D) CONSTRUCTION.—The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(2) SURVEYS.—

(A) STANDARD SURVEY.—

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[153] P.L. 101-508, §4008(h)(2)(L), added this sentence, effective as if included in the enactment of P.L. 100-203.

(i) IN GENERAL.—Each skilled nursing facility shall be subject to a standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a skilled nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The Secretary shall review each State's procedures for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(ii) CONTENTS.—Each standard survey shall include, for a case-mix stratified sample of residents—

(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

(II) written plans of care provided under subsection (b)(2) and an audit of the residents' assessments under subsection (b)(3) to determine the accuracy of such assessments and the adequacy of such plans of care, and

(III) a review of compliance with residents' rights under subsection (c).

(iii) FREQUENCY.—

(I) IN GENERAL.—Each skilled nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this subparagraph. The Statewide average interval between standard surveys of skilled nursing facilities under this subsection shall not exceed 12 months.

(II) SPECIAL SURVEYS.—If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) may be conducted within 2 months of any change of ownership, administration, management of a skilled nursing facility, or the director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

(B) EXTENDED SURVEYS.—

(i) IN GENERAL.—Each skilled nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

(ii) TIMING.—The extended survey shall be conducted immediately after the standard survey (or, if not practicable, not later than 2 weeks after the date of completion of the standard survey).

(iii) CONTENTS.—In such an extended survey, the survey team shall review and identify the policies and procedures which produced such substandard quality of care and shall determine whether the facility has complied with all the requirements described in subsections (b), (c), and (d). Such review shall include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, of in-service training, and, if appropriate, of contracts with consultants.

(iv) CONSTRUCTION.—Nothing in this paragraph shall be construed as requiring an extended or partial extended survey as a prerequisite to imposing a sanction against a facility under subsection (h) on the basis of findings in a standard survey.

(C) SURVEY PROTOCOL.—Standard and extended surveys shall be conducted—

(i) based upon a protocol which the Secretary has developed, tested, and validated by not later than January 1, 1990, and

(ii) by individuals, of a survey team, who meet such minimum qualifications as the Secretary establishes by not later than such date.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

(D) CONSISTENCY OF SURVEYS.—Each State and the Secretary shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

(E) SURVEY TEAMS.—

(i) IN GENERAL.—Surveys under this subsection shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

(ii) PROHIBITION OF CONFLICTS OF INTEREST.—A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d), or who has a personal or familial financial interest in the facility being surveyed.

(iii) TRAINING.—The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys under this subsection, including the auditing of resident assessments and plans of care. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

(3) VALIDATION SURVEYS.—

(A) IN GENERAL.—The Secretary shall conduct onsite surveys of a representative sample of skilled nursing facilities in each State, within 2 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (2). If the State has determined that an individual skilled nursing facility meets the requirements of subsections (b), (c), and (d), but the Secretary determines that the facility does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supersedes that of the State survey.

(B) SCOPE.—With respect to each State, the Secretary shall conduct surveys under subparagraph (A) each year with respect to at least 5 percent of the number of skilled nursing facilities surveyed by the State in the year, but in no case less than 5 skilled nursing facilities in the State.

(C) REMEDIES FOR SUBSTANDARD PERFORMANCE.—If the Secretary finds, on the basis of such surveys, that a State has failed to perform surveys as required under paragraph (2) or that a State's survey and certification performance otherwise is not adequate, the Secretary shall provide for an appropriate remedy, which may include the training of survey teams in the State.

(D) SPECIAL SURVEYS OF COMPLIANCE.—Where the Secretary has reason to question the compliance of a skilled nursing facility with any of the requirements of subsections (b), (c), and (d), the Secretary may conduct a survey of the facility and, on the basis of that survey, make independent and binding determinations concerning the extent to which the skilled nursing facility meets such reqirements.

(4) INVESTIGATION OF COMPLAINTS AND MONITORING COMPLIANCE.—Each State shall maintain procedures and adequate staff to—

(A) investigate complaints of violations of requirements by skilled nursing facilities, and

(B) monitor, on-site, on a regular, as needed basis, a skilled nursing facility's compliance with the requirements of subsections (b), (c), and (d), if—

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against substandard skilled nursing facilities.

(5) Disclosure of results of inspections and activities.—

(A) Public information.—Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys and certifications made respecting skilled nursing facilities, including statements of deficiencies, within 14 calendar days after such information is made available to those facilities, and approved[154] plans of correction,

(ii) copies of cost reports of such facilities filed under this title or title XIX,

(iii) copies of statements of ownership under section 1124, and

(iv) information disclosed under section 1126.

(B) Notice to ombudsman.—Each State shall notify the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965[155]) of the State's findings of noncompliance with any of the requirements of subsections (b), (c), and (d), or of any adverse action taken against a skilled nursing facility under paragraphs (1), (2), or (4) of subsection (h),[156] with respect to a skilled nursing facility in the State.

(C) Notice to physicians and skilled nursing facility administrator licensing board.—If a State finds that a skilled nursing facility has provided substandard quality of care, the State shall notify—

(i) the attending physician of each resident with respect to which such finding is made, and

(ii) the State board responsible for the licensing of the skilled nursing facility administrator at the facility.

(D) Access to fraud control units.—Each State shall provide its State medicaid fraud and abuse control unit (established under section 1903(q)) with access to all information of the State agency responsible for surveys and certifications under this subsection.[157]

(h) Enforcement Process.—

(1) In general.—If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) or otherwise, that a skilled nursing facility no longer meets a

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[154] P.L. 101-508, §4008(h)(2)(M), struck out "and" and substituted ", within 14 calendar days after such information is made available to those facilities, and approved", effective as if included in the enactment of P.L. 100-203.

[155] P.L. 89-73.

[156] P.L. 101-508, §4008(h)(2)(N), inserted "or of any adverse action taken against a skilled nursing facility under paragraphs (1), (2), or (4) of subsection (h),", effective as if included in the enactment of P.L. 100-203.

[157] P.L. 100-203, §4202(a)(2), added subsection (g). For the effective date, see Vol. II, P.L. 100-203, §4204(a).

See Vol. II, P.L. 101-239, §6901(d)(3), with respect to medicare waiver authority for certain demonstration projects in New York and Wisconsin.

requirement of subsection (b), (c), or (d), and further finds that the facility's deficiencies—

(A) immediately jeopardize the health or safety of its residents, the State shall recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(i); or

(B) do not immediately jeopardize the health or safety of its residents, the State may recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(ii).

If a State finds that a skilled nursing facility meets the requirements of subsections (b), (c), and (d), but, as of a previous period, did not meet such requirements, the State may recommend a civil money penalty under paragraph (2)(B)(ii) for the days in which it finds that the facility was not in compliance with such requirements.

(2) SECRETARIAL AUTHORITY.—

(A) IN GENERAL.—With respect to any skilled nursing facility in a State, if the Secretary finds, or pursuant to a recommendation of the State under paragraph (1) finds, that a skilled nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e), and further finds that the facility's deficiencies—

(i) immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (B)(iii), or terminate the facility's participation under this title and may provide, in addition, for one or more of the other remedies described in subparagraph (B); or

(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (B).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a skilled nursing facility's deficiencies. If the Secretary finds, or pursuant to the recommendation of the State under paragraph (1) finds, that a skilled nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (B)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

(B) SPECIFIED REMEDIES.—The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) DENIAL OF PAYMENT.—The Secretary may deny any further payments under this title with respect to all individuals entitled to benefits under this title in the facility or with respect to such individuals admitted to the facility after the effective date of the finding.

(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(iii) APPOINTMENT OF TEMPORARY MANAGEMENT.—In consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the Secretary may provide for other specified remedies, such as directed plans of correction.

(C) CONTINUATION OF PAYMENTS PENDING REMEDIATION.—The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the findings[158], under this title with respect to a skilled nursing facility not in compliance with a requirement of subsection (b), (c), or (d), if—

(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility,

(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(iii) the facility agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

(D) ASSURING PROMPT COMPLIANCE.—If a skilled nursing facility has not complied with any of the requirements of subsections (b), (c), and (d), within 3 months after the date the facility is found to be out of compliance with such requirements, the Secretary shall impose the remedy described in subparagraph (B)(i) for all individuals who are admitted to the facility after such date.

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[158] P.L. 101-239, §6901(d)(4)(D), inserted "after the effective date of the findings", effective as if included in the enactment of P.L. 100-203.

(E) REPEATED NONCOMPLIANCE.—In the case of a skilled nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2), has been found to have provided substandard quality of care, the Secretary shall (regardless of what other remedies are provided)—

(i) impose the remedy described in subparagraph (B)(i), and

(ii) monitor the facility under subsection (g)(4)(B),

until the facility has demonstrated, to the satisfaction of the Secretary, that it is in compliance with the requirements of subsections (b), (c), and (d), and that it will remain in compliance with such requirements.

(3) EFFECTIVE PERIOD OF DENIAL OF PAYMENT.—A finding to deny payment under this subsection shall terminate when the Secretary finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d).

(4) IMMEDIATE TERMINATION OF PARTICIPATION FOR FACILITY WHERE SECRETARY FINDS NONCOMPLIANCE AND IMMEDIATE JEOPARDY.—If the Secretary finds that a skilled nursing facility has not met a requirement of subsection (b), (c), or (d), and finds that the failure immediately jeopardizes the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(B)(iii), or the Secretary shall terminate the facility's participation under this title. If the facility's participation under this title is terminated, the State shall provide for the safe and orderly transfer of the residents eligible under this title consistent with the requirements of subsection (c)(2).

(5) CONSTRUCTION.—The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), and (iii) of paragraph (2)(B) may be imposed during the pendency of any hearing.

(6) SHARING OF INFORMATION.—Notwithstanding any other provision of law, all information concerning skilled nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such facilities to Federal or State employees for purposes consistent with the effective administration of programs established under this title and title XIX, including investigations by State medicaid fraud control units.[159]

(i) CONSTRUCTION.—Where requirements or obligations under this section are identical to those provided under section 1919 of this Act, the fulfillment of those requirements or obligations under section

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[159] P.L. 100-203, §4203(a)(2), added subsection (h). For the effective date, see Vol. II, P.L. 100-203, §4204(b), as added by P.L. 100-360, §411(l)(9)(B)(iii).

1919 shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

ESSENTIAL ACCESS COMMUNITY HOSPITAL PROGRAM[160]

SEC. 1820. [42 U.S.C. 1395i-4] (a) IN GENERAL.—There is hereby established a program under which the Secretary—

(1) shall make grants to not more than 7 States to carry out the activities described in subsection (d)(1);

(2) shall make grants to eligible hospitals and facilities (or consortia of hospitals and facilities) to carry out the activities described in subsection (d)(2); and

(3) shall designate (under subsection (i)) hospitals and facilities located in States receiving grants under paragraph (1) as essential access community hospitals or rural primary care hospitals.

(b) ELIGIBILITY OF STATES FOR GRANTS.—A State is eligible to receive a grant under subsection (a)(1) only if the State submits to the Secretary, at such time and in such form as the Secretary may require, an application containing—

(1) assurances that the State—

(A) has developed, or is in the process of developing, a State rural health care plan that—

(i) provides for the creation of one or more rural health networks (as defined in subsection (g)) in the State,

(ii) promotes regionalization of rural health services in the State,

(iii) improves access to hospital and other health services for rural residents of the State, and

(iv) enhances the provision of emergency and other transportation services related to health care;

(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State and rural hospitals located in the State (or, in the case of a State in the process of developing such plan, that assures the Secretary that it will consult with its State hospital association and rural hospitals located in the State in developing such plan); and

(C) has designated, or is in the process of designating, rural non-profit or public hospitals or facilities located in the State as essential access community hospitals or rural primary care hospitals within such networks; and

(2) such other information and assurances as the Secretary may require.

(c) ELIGIBILITY OF HOSPITALS AND CONSORTIA FOR GRANTS.—

(1) IN GENERAL.—Except as provided in paragraph (3), a hospital or facility is eligible to receive a grant under subsection (a)(2) only if the hospital or facility—

(A) is located in a State receiving a grant under subsection (a)(1);

(B) is designated as an essential access community hospital or a rural primary care hospital by the State in which it is located or is a member of a rural health network (as defined in subsection (g));

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[160] P.L. 101-239, §6003(g)(1)(A), added §1820, effective December 19, 1989.

(C) submits to the State in which it is located and to the Secretary, at such time and in such form as the Secretary may require, an application containing such information and assurances as the Secretary may require; and

(D) the State in which the hospital or facility is located certifies to the Secretary that—

(i) the receiving of such a grant by the hospital or facility is consistent with the State's rural health care plan (described in subsection (b)(1)(A)), and

(ii) the State has approved the application submitted under subparagraph (C).

(2) TREATMENT OF CONSORTIA.—A consortium of hospitals or facilities each of which is part of the same rural health network is eligible to receive a grant under subsection (a)(2) if each of its members would individually be eligible to receive such a grant.

(3) ELIGIBILITY OF RPC HOSPITALS NOT LOCATED IN A STATE RECEIVING GRANT.—A facility designated as a rural primary care hospital by the Secretary under subsection (i)(2)(C) shall be eligible to receive a grant under subsection (a)(2).

(d) ACTIVITIES FOR WHICH GRANTS MAY BE USED.—

(1) GRANTS TO STATES.—A State shall use a grant received under subsection (a)(1) to carry out the [161] program established under this section in the State. Such grant may be used for engaging in activities relating to planning and implementing a rural health care plan and rural health networks, designating hospitals or facilities in the State as essential access community hospitals or rural primary care hospitals, and developing and supporting communication and emergency transportation systems.

(2) GRANTS TO HOSPITALS, FACILITIES, AND CONSORTIA.—A hospital or facility shall use a grant received under subsection (a)(2) to finance the costs it incurs in converting itself to a rural primary care hospital or an essential access community hospital or in becoming part of a rural health network in the State in which it is located, including capital costs, costs incurred in the development of necessary communications systems, and costs incurred in the development of an emergency transportation system. A consortium shall use a grant received under subsection (a)(2) to finance the costs it incurs in converting hospitals or facilities that are part of the consortium into rural primary care hospitals or in developing and implementing a rural health network consisting of its members in the State in which it is located, including capital costs, costs incurred in the development of necessary communications systems, and costs incurred in the development of an emergency transportation system.

(e) DESIGNATION BY STATE OF ESSENTIAL ACCESS COMMUNITY HOSPITALS.—A State may designate a hospital as an essential access community hospital only if the hospital—

(1) is located in a rural area (as defined in section 1886(d)(2)(D));

(2)(A) is located more than 35 miles from any hospital that either (i) has been designated as an essential access community hospital, (ii) is classified by the Secretary as a rural referral center under section 1886(d)(5)(C), or (iii) is located in an urban area that meets the criteria for classification as a regional referral center under such section, or (B) meets such other criteria relating to geographic location as the State may impose with the approval of the Secretary;

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[161] P.L. 101-508, §4008(m)(2)(B)(i), struck out "demonstration", effective November 5, 1990.

(3) has at least 75 inpatient beds or is located more than 35 miles from any other hospital;

(4) has in effect an agreement to provide emergency and medical backup services to rural primary care hospitals participating in the rural health network of which it is a member and throughout its service area;

(5) has in effect an agreement, with each rural primary care hospital participating in the rural health network of which it is a member, to accept patients transferred from such primary care hospital, to receive data from and transmit data to such primary care hospital, and to provide staff privileges to physicians providing care at such primary care hospital; and

(6) meets any other requirements imposed by the State with the approval of the Secretary.

(f) DESIGNATION BY STATE OF RURAL PRIMARY CARE HOSPITALS.—

(1) CRITERIA FOR DESIGNATION.—A State may designate a facility as a rural primary care hospital only if the facility—

(A) is located in a rural area (as defined in section 1866(d)(2)(D)), or is located in a county whose geographic area is substantially larger than the average geographic area for urban counties in the United States and whose hospital service area is characteristic of service areas of hospitals located in rural areas[162];

(B) at the time such facility applies to the State for designation as a rural primary care hospital, is a hospital (or, in the case of a facility that closed during the 12-month period that ends on the date the facility applies for such designation, at the time the facility closed),[163] with a participation agreement in effect under section 1866(a) and had not been found, on the basis of a survey under section 1864, to be in violation of any requirement to participate as a hospital under this title;

(C) has ceased, or agrees (upon the approval of such application) to cease, providing inpatient care (except as required under subparagraph (F));

(D) in the case of a facility that is a member of a rural health network, has in effect an agreement to participate with other hospitals and facilities in the communications system of such network, including the network's system for the electronic sharing of patient data, including telemetry and medical records, if the network has in operation such a system;

(E) makes available 24-hour emergency care;

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[162] P.L. 101-508, §4008(d)(3), inserted ", or is located in a county whose geographic area is substantially larger than the average geographic area for urban counties in the United States and whose hospital service area is characteristic of service areas of hospitals located in rural areas", effective November 5, 1990.

[163] P.L. 101-508, §4008(d)(2), struck out "is a hospital," and substituted "is a hospital (or, in the case of a facility that closed during the 12-month period that ends on the date the facility applies for such designation, at the time the facility closed),", effective November 5, 1990. Material to be stricken probably should read "is a hospital".

(F) provides not more than 6 inpatient beds (meeting such conditions as the Secretary may establish) for providing inpatient care for a period not to exceed 72 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions) to patients requiring stabilization before discharge or transfer to a hospital;

(G) meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraph (E),

(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietician, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off-site basis, and

(iii) the inpatient care described in subparagraph (F) may be provided by a physician's assistant or nurse practitioner, subject to the oversight of a physician; and

(H) meets the requirements of subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of that paragraph.

(2) PREFERENCE GIVEN TO HOSPITALS OR FACILITIES PARTICIPATING IN RURAL HEALTH NETWORK.—In designating facilities as rural primary care hospitals under paragraph (1), the State shall give preference to hospitals or facilities participating in a rural health network.

(3) PERMITTING RURAL PRIMARY CARE HOSPITALS TO MAINTAIN SWING BEDS.—Nothing in this subsection shall be construed to prohibit a State from designating a facility as a rural primary care hospital solely because the facility has entered into an agreement with the Secretary under section 1883 under which the facility's inpatient hospital facilities may be used for the furnishing of extended care services.

(g) RURAL HEALTH NETWORK DEFINED.—For purposes of this section, the term "rural health network" means, with respect to a State, an organization—

(1) consisting of—

(A) at least 1 hospital that—

(i) the State has designated or plans to designate as an essential access community hospital under subsection (b)(1)(C),

(ii) is classified by the Secretary as a regional[164] referral center under section 1886(d)(5)(C), or

(iii) is located in an urban area and meets the criteria for classification as a regional referral center under such section, and

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[164] P.L. 101-508, §4008(m)(2)(B)(ii), struck out "rural" and substituted "regional", effective November 5, 1990

(B) at least 1 facility that the State has designated or plans to designate as a rural primary care hospital, and

(2) the members of which have entered into agreements regarding—

(A) patient referral and transfer,

(B) the development and use of communications systems, including (where feasible) telemetry systems and systems for electronic sharing of patient data, and

(C) the provision of emergency and non-emergency transportation among the members.

(h) LIMIT ON AMOUNT OF GRANT TO HOSPITAL OR FACILITY.—A grant made to a hospital or facility under subsection (a)(2) may not exceed $200,000.

(i) ELIGIBILITY OF HOSPITALS OR FACILITIES FOR DESIGNATION BY SECRETARY.—

(1) ESSENTIAL ACCESS COMMUNITY HOSPITAL.—(A) The Secretary shall designate a hospital as an essential access community hospital if the hospital—

(i) is located in a State receiving a grant under subsection (a)(1);

(ii) is designated as an essential access community hospital by the State in which it is located (except as provided in subparagraph (B)); and

(iii) meets such other criteria as the Secretary may require.

(B) In the case of a hospital that is not eligible for designation as an essential access community hospital under this paragraph solely because it is not designated as an essential access community hospital by the State in which it is located, the Secretary may designate such hospital as an essential access community hospital under this paragraph if the hospital is not so designated by the State in which it is located solely because of its failure to meet the criteria described in paragraph (3) of subsection (e).

(2) RURAL PRIMARY CARE HOSPITAL.—(A) The Secretary shall designate a facility as a rural primary care hospital if the facility—

(i) is located in a State receiving a grant under subsection (a)(1);

(ii) is designated as a rural primary care hospital by the State in which it is located (except as provided in subparagraph (B)); and

(iii) meets such other criteria as the Secretary may require.

(B) In the case of a facility that is not eligible for designation as a rural primary care hospital under this paragraph solely because it is not designated as a rural primary care hospital by the State in which it is located, the Secretary may designate such facility as a rural primary care hospital under this paragraph if the facility is not so designated by the State in which it is located solely because of its failure to meet the criteria described in subparagraphs (C), (F), or (G) of subsection (f)(1).

(C) The Secretary may designate not more than 15 facilities as rural primary care hospitals under this paragraph that do not meet the requirements of clauses (i) and (ii) of subparagraph (A) if such a facility meets the criteria described in subparagraphs (A), (B), and (E) of subsection (f)(1), except that nothing in this subparagraph shall be construed to prohibit the Secretary from designating a facility as a rural primary care hospital solely because the facility has entered into an agreement with the Secretary under section 1883 under which the facility's inpatient hospital facilities may be used for the furnishing of extended care services. In designating facilities as rural primary care hospitals under this subparagraph, the Secretary shall give preference to facilities not meeting the requirements of clause (i) of subparagraph (A) that have entered into an agreement described in subsection (g)(2) with a rural health network located in a State receiving a grant under subsection (a)(1).[165]

(j) WAIVER OF CONFLICTING PART A PROVISIONS.—The Secretary is authorized to waive such provisions of this part and part C[166] as are necessary to conduct the program established under this section.

(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for each of the fiscal years 1990, 1991, and 1992—

(1) $10,000,000 for grants to States under subsection (a)(1); and

(2) $15,000,000 for grants to hospitals, facilities, and consortia under subsection (a)(2).

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED[167]

ESTABLISHMENT OF SUPPLEMENTARY MEDICAL INSURANCE PROGRAM FOR THE AGED AND THE DISABLED

SEC. 1831. [42 U.S.C. 1395j] There is hereby established a voluntary insurance program to provide medical insurance benefits in accordance with the provisions of this part for aged and disabled individuals who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

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[165] P.L. 101-508, §4008(d)(1), added this sentence, effective November 5, 1990.

[166] P.L. 101-508, §4008(m)(2)(B)(iii), inserted "and part C", effective November 5, 1990.

[167] See Vol. II, P.L. 98-369, §2304(a), with respect to pacemaker reimbursement review and reform; and §2323(e), with respect to monitoring of hepatitis vaccine.

See Vol. II, P.L. 99-509, §9305(k) with respect to the prior and concurrent authorization demonstration project; §9331(c)(1) with respect to the Medicare economic index; §9331(d) with respect to the development and use of HCFA common procedure coding system; and §9332(a)(4), as amended by P.L. 100-203, §4041(a)(3)(B)(ii) and (iii), with respect to carrier performance measures and carrier bonuses.

See Vol. II, P.L. 100-203, §4039(e), with respect to a moratorium on prior authorization for home health and post-hospital extended care services; §4048(b), with respect to the development of a uniform relative value guide; §4050, with respect to fee schedules for physician pathology services; §4051(b) and (c)(2), with respect to adjustment in the Medicare prevailing charges for diagnostic tests; §4056, with respect to physician payment studies; §4061, with respect to the extension of reduction in payments for some Part B items and services, under the sequester order of November 20, 1987; §4062(a), with respect to the one-year freeze on limitations on allowable charges for items and services (other than physicians' services); §4064(a)(1), with respect to a 3-month freeze in fee schedules for clinical laboratory diagnostic tests; §4079, with respect to demonstration projects to provide payment on a prepaid, capitated basis for community nursing and ambulatory care furnished to Medicare beneficiaries; §4082(d), with respect to a study by the Comptroller General; and §4085(e), with respect to the capacity to set geographic payment limits.

See Vol. II, P.L. 101-239, §6112(b), with respect to rental payments for enteral and parenteral pumps; §6113(c) and (e), with respect to the development of criteria regarding consultation with a physician; §6134, with respect to a study of payment for portable X-ray services; and §6142, with respect to a study of reimbursement for blood clotting factor for hemophilia patients.

See Vol. II, P.L. 101-508, §4102(c)(1) and (2), with respect to a reduction in prevailing charge levels for certain radiology services; §4152(d), with respect to the freeze in reasonable charges for parenteral and enteral nutrients, supplies, and equipment during 1991; §4153(b)(1), with respect to provisions relating to eyeglasses; §4156(b), with respect to a study and report of effects of coverage of osteoporosis drugs; §4158, with respect to a reduction in payments under Part B during the final 2 months of 1990; §4159, with respect to payments for medical education costs; and §4164(c), with respect to the directory of unique physician identifier numbers.

SCOPE OF BENEFITS

SEC. 1832. [42 U.S.C. 1395k] (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph (2); and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A)[168] home health services (other than items described in subparagraph (G) or subparagraph (I)[169])[170];

(B) medical and other health services (other than items described in subparagraph (G) or subparagraph (I)[171])[172] furnished by a provider of services or by others under arrangement with them made by a provider of services, excluding—

(i) physician services except where furnished by—

(I) a resident or intern of a hospital, or

(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital) where the conditions specified in paragraph (7) of such section are met,

(ii) services for which payment may be made pursuant to section 1835(b)(2),[173]

(iii) services described by section 1861(s)(2)(K)(i), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist;[174]

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[168] P.L. 101-234, §201(a)(1), struck out "(i)".

[169] P.L. 101-508, §4153(a)(2)(A)(i), inserted "or subparagraph (I)", applicable to items furnished on or after January 1, 1991.

[170] P.L. 100-203, §4062 [as amended by P.L. 101-508, §4152(h)], inserted "(other than items described in subparagraph (G))", applicable to covered items (other than oxygen and oxygen equipment) furnished on or after January 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989.

P.L. 101-234, §201(a)(1), struck out "and home intravenous drug therapy services, and", and clause (ii), effective January 1, 1990. [For clause (ii) as it formerly read, see Vol. III, P.L. 101-234.]

[171] P.L. 101-508, §4153(a)(2)(A)(i), inserted "or subparagraph (I)", applicable to items furnished on or after January 1, 1991.

[172] P.L. 100-203, §4062 [as amended by P.L. 101-508, §4152(h)], inserted "(other than items described in subparagraph (G))", applicable to covered items (other than oxygen and oxygen equipment) furnished on or after January 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989.

[173] P.L. 101-508, §4155(b)(1)(A), struck out "and".

[174] P.L. 99-509, §9320(d)(3), added clause (iii). For the effective date, see Vol. II, P.L. 99-509, §9320(i), as amended by P.L. 100-485.

P.L. 101-508, §4157(b), amended clause (iii) in its entirety, applicable to services furnished on or after January 1, 1991. [For clause (iii) as it formerly read, see Vol. III, P.L. 101-508.]

(iv) services of a nurse practitioner or clinical nurse specialist provided in a rural area (as defined in section 1886(d)(2)(D)); and[175]

(C) outpatient physical therapy services (other than services to which the second sentence of section 1861(p) applies) and outpatient occupational therapy services (other than services to which such sentence applies through the operation of section 1861(g));

(D)(i)[176] rural health clinic services and (ii) Federally qualified health center services[177];

(E) comprehensive outpatient rehabilitation facility services;

(F) facility services furnished in connection with surgical procedures specified by the Secretary—

(i) pursuant to section 1833(i)(1)(A) and performed in an ambulatory surgical center (which meets health, safety, and other standards specified by the Secretary in regulations) if the center has an agreement in effect with the Secretary by which the center agrees to accept the standard overhead amount determined under section 1833(i)(2)(A) as full payment for such services (including intraocular lens in cases described in section 1833(i)(2)(A)(iii)) and to accept an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for all such services (including intraocular lens in cases described in section 1833(i)(2)(A)(iii)) furnished by the center to individuals enrolled under this part, or

(ii) pursuant to section 1833(i)(1)(B) and performed by a physician, described in paragraph (1), (2), or (3) of section 1861(r), in his office, if the Secretary has determined that—

(I) a quality control and peer review organization (having a contract with the Secretary under part B of title XI of this Act) is willing, able, and has agreed to carry out a review (on a sample or other reasonable basis) of the physician's performing such procedures in the physician's office,

(II) the particular physician involved has agreed to make available to such organization such records as the Secretary determines to be necessary to carry out the review, and

(III) the physician is authorized to perform the procedure in a hospital located in the area in which the office is located,

and if the physician agrees to accept the standard overhead amount determined under section 1833(i)(2)(B) as full payment for such services and to accept payment on an assignment-related basis with respect to payment for all services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1861(s) and furnished in connection with such surgical procedure to individuals enrolled under this part;[178]

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[175] P.L. 101-508, §4155(b)(1)(C), added clause (iv), applicable to services furnished on or after January 1, 1991.

[176] P.L. 101-508, §4161(a)(3)(A), redesignated subparagraph (D) as clause (i).

[177] P.L. 101-508, §4161(a)(3)(A), added "and" and clause (ii). For the effective date, see Vol. II, P.L. 101-508, §4161(a)(8).

[178] P.L. 101-239, §6116(a)(2)(A), struck out "and".

(G) covered items (described in section 1834(a)(13)) furnished by a provider of services or by others under arrangements with them made by a provider of services;[179]

(H) outpatient rural primary care hospital services (as defined in section 1861(mm)(3));[180]

(I) prosthetic devices and orthotics and prosthetics (described in section 1834(h)(4)) furnished by a provider of services or by others under arrangements with them made by a provider of services; and[181]

(J) partial hospitalization services provided by a community mental health center (as described in section 1861(ff)(2)(B)).[182] [183]

(b) For definitions of "spell of illness",[184] "medical and other health services",[185] and other terms used in this part, see section 1861.

PAYMENT OF BENEFITS[186]

SEC. 1833. [42 U.S.C. 1395l] (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund[187], in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b),[188] (B) with respect to items and services described in section 1861(s)(10)(A), the amounts paid shall be 100 percent of the reasonable charges for

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[179] P.L. 100-203, §4062 [as amended by P.L. 101-508, §4152(h)], added subparagraph (G), applicable to covered items (other than oxygen and oxygen equipment) furnished on or after January 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989.

P.L. 101-239, §6116(a)(2)(B), struck out the period and substituted "; and".

P.L. 101-508, §4153(a)(2)(A)(ii), struck out "and".

[180] P.L. 101-239, §6116(a)(2)(C), added subparagraph (H), effective December 19, 1989.

P.L. 101-508, §4153(a)(2)(A)(iii), struck out a period and substituted "; and".

P.L. 101-508, §4162(b)(1)(A), struck out "and".

[181] P.L. 101-508, §4153(a)(2)(A)(iv), added subparagraph (I), applicable to items furnished on or after January 1, 1991.

P.L. 101-508, §4162(b)(1)(B), struck out a period and substituted "; and".

[182] P.L. 101-508, §4162(b)(1)(C), added subparagraph (J), applicable with respect to partial hospitalization services provided on or after October 1, 1991.

[183] P.L. 101-234, §201(a)(1), struck out "In the case of in-home care (described in paragraph (2)(A)(ii)) provided to a chronically dependent individual on any day, such care provided for 3 hours or less on the day shall be counted (for purposes of the limitation in such paragraph) as 3 hours of such care.", effective January 1, 1990.

[184] P.L. 101-234, §101(a)(1), inserted " 'spell of illness',", effective January 1, 1990.

[185] *P.L. 101-234, §101(a)(1), added a comma, effective January 1, 1990.*

[186] See Vol. II, P.L. 99-272, §9401(e), with respect to a study required.

[187] P.L. 101-234, §202(a), struck out "or, as provided in section 1841A(c), from the Federal Catastrophic Drug Insurance Trust Fund", effective January 1, 1990.

[188] See Vol. II, P.L. 100-360, §222, with respect to the adjustment of contracts with prepaid health plans.

such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule under subsection (h)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis, or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate, (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, (F) with respect to clinical social worker services under section 1861(s)(2)(N), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under clause (L),[189] (G) with respect to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the least of the actual charge, the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848[190])[191] if the services had been performed by an anesthesiologist, or the fee schedule for such services established by the Secretary in accordance with subsection (l),[192] (I) with respect to covered items (described in section 1834(a)(13)), the amounts paid shall be the amounts described in section 1834(a)(1),[193] and (J) with respect to expenses incurred for radiologist services (as defined in section 1834(b)(6))[194], subject to section 1848,[195] the amounts paid shall be

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[189] P.L. 101-239, §6113(b)(3)(A), added clause (F), applicable to services furnished on or after July 1, 1990.

[190] P.L. 101-508, §4118(f)(2)(D), struck out ", as the case may be", effective November 5, 1990.

[191] P.L. 101-239, §6102(e)(5), inserted "(or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848, as the case may be)", effective December 19, 1989.

[192] P.L. 99-509, §9320(e)(1), added subparagraph (H). For the effective date, see Vol. II, P.L. 99-509, §9320(i), as amended by P.L 100-485.

[193] P.L. 100-203, §4062 [as amended by P.L. 101-508, §4152(h)], added clause (I), applicable to covered items (other than oxygen and oxygen equipment) furnished on or after January 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989.

[194] P.L. 101-239, §6102(f)(2)(A), inserted "or physician pathology services", applicable to services furnished on or after January 1, 1991.

P.L. 101-508, §4104(b)(1), struck out "or physician pathology services", applicable to services furnished on or after January 1, 1991.

[195] P.L. 101-239, §6102(e)(6)(A), inserted "subject to section 1848,", effective December 19, 1989.

80 percent of the lesser of the actual charge for the services or the amount provided under the fee schedule established under section 1834(b)[196],[197] (K) with respect to certified nurse-midwife services under section 1861(s)(2)(L), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (but in no event shall such fee schedule exceed 65 percent of the prevailing charge that would be allowed for the same service performed by a physician, or, for services furnished on or after January 1, 1992, 65 percent of the fee schedule amount provided under section 1848 for the same service performed by a physician[198]),[199] (L) with respect to qualified psychologist services under section 1861(s)(2)(M), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph,[200] (M) with respect to prosthetic devices and orthotics and prosthetics (as defined in section 1834(h)(4)), the amounts paid shall be the amounts described in section 1834(h)(1),[201] (M) with respect to services described in section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area), the amounts paid shall be 80 percent of the lesser of the actual charge or the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) if the services had been performed by a physician (subject to the limitation described in subsection (r)(2)) and[202] (N) with respect to expenses incurred for physicians' services (as defined in section 1848(j)(3)), the amounts paid shall be 80 percent of the payment basis determined under section 1848(a)(1)[203];

(2) in the case of services[204] described in section 1832(a)(2)

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[196] P.L. 101-239, §6102(f)(2)(B), inserted "or section 1834(f), respectively", applicable to services furnished on or after January 1, 1991.

P.L. 101-508, §4104(b)(1), struck out "or section 1834(f), respectively", applicable to services furnished on or after January 1, 1991.

[197] P.L. 100-203, §4049(a)(1), added this clause (J), applicable to services performed on or after April* 1, 1989**.

*P.L. 100-203, §4049 [as amended by P.L. 101-508, §4118(h)(2)], struck out "January" and substituted "April", effective as if included in the enactment of P.L. 100-203.

**P.L. 101-239, §6102(e)(6)(B), struck out ", and until such time as the Secretary of Health and Human Services implements physician fee schedules based on the relative value scale developed under section 1845(e) of the Social Security Act".

[198] P.L. 101-239, §6102(e)(7), inserted ", or, for services furnished on or after January 1, 1992, 65 percent of the fee schedule amount provided under section 1848 for the same service performed by a physician", effective December 19, 1989.

[199] P.L. 101-234, §201(a)(1), inserted "and".

P.L. 101-508, §4153(a)(2)(B)(i), struck out "and".

P.L. 101-508, §4155(b)(2)(A), also struck out "and".

[200] P.L. 101-234, §201(a)(1), struck out "and".

P.L. 101-239, §6102(e)(1)(A), also struck out "and".

P.L. 101-508, §4153(a)(2)(B)(ii), added a comma.

[201] P.L. 101-234, §201(a)(1), struck out subparagraph (M), effective January 1, 1990. [For subparagraph (M) as it formerly read, see Vol. III, P.L. 101-234.]

P.L. 101-508, §4153(a)(2)(B)(ii), added this subparagraph (M), applicable to items furnished on or after January 1, 1991.

[202] P.L. 101-508, §4155(b)(2)(B), added this subparagraph (M), applicable to services furnished on or after January 1, 1991.

P.L. 101-239, §6102(e)(1)(B), added "and".

[203] P.L. 101-239, §6102(e)(1)(B), added clause (N), effective December 19, 1989.

[204] P.L. 101-234, §201(a)(1), struck out "(other than covered outpatient drugs)", effective January 1, 1990.

(except those services described in subparagraphs[205] (D), (E), (F), (G), (H), and (I)[206] of such section and unless otherwise specified in section 1881)—

(A) with respect to home health services[207], to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), and to items and services described in section 1861(s)(10)(A), the lesser of—

(i) the reasonable cost of such services, as determined under section 1861(v), or

(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);

(B) with respect to other items and services (except those described in subparagraph (C), (D), or (E)[208] of this paragraph and except as may be provided in section 1886)—

(i) the lesser of—

(I) the reasonable cost of such services, as determined under section 1861(v), or

(II) the customary charges with respect to such services,

less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such other services exceed 80 percent of such reasonable cost, or

(ii) if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, 80 percent of the amount determined in accordance with section 1814(b)(2), or[209]

(iii) if (and for so long as) the conditions described in section 1814(b)(3) are met, the amounts determined under the reimbursement system described in such section;

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[205] P.L. 101-234, §201(a)(1), struck out "(A)(ii),", effective January 1, 1990.

[206] P.L. 101-239, §6116(b)(1)(A), struck out "and (G)" and substituted "(G), and (H)", effective December 19, 1989.

P.L. 101-508, §4153(a)(2)(C)(i), struck out "and (H)" and substituted "(H), and (I)", applicable to items furnished on or after January 1, 1991.

[207] P.L. 100-203, §4062 [as amended by P.L. 101-508, §4152(h)], struck out "(other than durable medical equipment)", applicable to covered items (other than oxygen and oxygen equipment) furnished on or after January 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989.

[208] P.L. 101-234, §201(a)(1), struck out "(E), or (F)" and substituted "or (E)", effective January 1, 1990.

[209] See Vol. II, P.L. 98-369, §2308(b)(1), with respect to rules applicable to the nominality test.

(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services;

(D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule determined under subsection (h)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis, to a provider having an agreement under section 1866, or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate for such tests; and[210]

(E) with respect to—

(i) outpatient hospital radiology services (including diagnostic and therapeutic radiology, nuclear medicine and CAT scan procedures, magnetic resonance imaging, and ultrasound and other imaging services, but excluding screening mammography[211]), and

(ii) effective for procedures performed on or after October 1, 1989, diagnostic procedures (as defined by the Secretary) described in section 1861(s)(3) (other than diagnostic x-ray tests and diagnostic laboratory tests),

the amount determined under subsection (n);[212]

[(F) Stricken.[213]]

(3) in the case of services described in subparagraphs (D)[214] and (E) of section 1832(a)(2), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A) and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion) exceed 80 percent of such costs;

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[210] P.L. 101-234, §201(a)(1), inserted "and".

[211] P.L. 101-234, §201(a)(1), struck out ", but excluding screening mammography", effective January 1, 1990.

P.L. 101-508, §4163(d)(1), inserted ", but excluding screening mammography", applicable to screening mammography performed on or after January 1, 1991.

[212] P.L. 100-203, §4066(a)(1)(C), added subparagraph (E), applicable to outpatient hospital radiology services furnished on or after October 1, 1988, and other diagnostic procedures performed on or after October 1, 1989.

P.L. 101-234, §201(a)(1), struck out "and".

[213] P.L. 101-234, §201(a)(1), struck out subparagraph (F), effective January 1, 1990. [For subparagraph (F) as it formerly read, see Vol. III, P.L. 101-234.]

[214] P.L. 101-234, §201(a)(1), struck out "(A)(ii), (D)," and substituted "(D)", effective January 1, 1990.

(4) in the case of facility services described in section 1832(a)(2)(F), and outpatient hospital facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1)(A), the applicable amount as determined under paragraph (2) or (3) of subsection (i);[215]

(5) in the case of covered items (described in section 1834(a)(13)) the amounts described in section 1834(a)(1);[216]

(6) in the case of outpatient rural primary care hospital services, the amounts described in section 1834(g); and[217] [218]

(7) in the case of prosthetic devices and orthotics and prosthetics (as described in section 1834(h)(4)), the amounts described in section 1834(h).[219]

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75 for calendar years before 1991 and $100 for 1991 and subsequent years[220]; except that (1) such total amount shall not include expenses incurred for items and services described in section 1861(s)(10)(A)[221], (2) such deductible shall not apply with respect to home health services[222] [223], (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on an assignment-related basis, or to a provider having an agreement under section 1866, or (B) on the basis of a negotiated rate determined under subsection (h)(6),[224] (4) such deductible shall not apply with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), and (5) such deductible shall not apply to Federally qualified health center services[225]. The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence. The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1813(a)(2) to blood or blood cells furnished the individual in the year.

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[215] P.L. 101-239, §6116(b)(1)(B), struck out "and".

[216] P.L. 100-203, §4062 [as amended by P.L. 101-508, §4152(h)], added paragraph (5), applicable to covered items (other than oxygen and oxygen equipment) furnished on or after January 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989.

P.L. 101-239, §6116(b)(1)(C), struck out the period and substituted "; and".

P.L. 101-508, §4153(a)(2)(C)(ii), struck out "and".

[217] P.L. 101-239, §6116(b)(1)(D), added paragraph (6), effective December 19, 1989.

P.L. 101-508, §4153(a)(2)(C)(iii), struck out a period and substituted "; and".

[218] P.L. 101-234, §201(a)(1), struck out "Payment for in-home care for chronically dependent individuals shall be paid on the basis of an hour of such care provided. In applying paragraph (2) in the case of an organization receiving payment under clause (A) of paragraph (1) or under a reasonable cost reimbursement contract under section 1876 and providing coverage of in-home care, the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect the aggregate increase in payments that would otherwise be made with respect to enrollees in the organization if payments were made other than under such clause or such a contract if payments were to be made on an individual-by-individual basis.", effective January 1, 1990.

[219] P.L. 101-508, §4153(a)(2)(C)(iv), added paragraph (7), applicable to items furnished on or after January 1, 1991.

[220] P.L. 101-508, §4302, inserted "for calendar years before 1991 and $100 for 1991 and subsequent years", effective November 5, 1990.

[221] P.L. 101-234, §201(a)(1), struck out "or for covered outpatient drugs", effective January 1, 1990.

[222] P.L. 101-234, §201(a)(1), struck out "or with respect to covered outpatient drugs", effective January 1, 1990.

[223] P.L. 101-234, §201(a)(1), struck out "and home intravenous drug therapy services", effective January 1, 1990.

[224] P.L. 101-508, §4161(a)(3)(B)(i), struck out "and".

[225] P.L. 101-508, §4161(a)(3)(B)(ii), inserted ", and" and paragraph (5). For the effective date, see Vol. II, P.L. 101-508, §4161(a)(8).

(c)[226] Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b)[227] only 62 1/2 percent of such expenses.[228]

For purposes of this subsection[229], the term "treatment" does not include brief office visits (as defined by the Secretary) for the sole purpose of monitoring or changing drug prescriptions used in the treatment of such disorders or partial hospitalization services that are not directly provided by a physician.

(d)[230] No payment may be made under this part with respect to any services furnished an individual to the extent that such individual is entitled (or would be entitled except for section 1813) to have payment made with respect to such services under part A.

(e) No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

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[226] P.L. 101-234, §201(a)(1), struck out the former subsection (c), effective January 1, 1990. [For subsection (c) as it formerly read, see Vol. III, P.L. 101-234.]

P.L. 101-234, §201(a)(1), struck out "(d)(1)" and substituted "(c)", effective January 1, 1990.

See Vol. II, P.L. 101-234, §203(b), with respect to the adjustment of contracts with prepaid health plans.

[227] P.L. 100-360, §201(a)(1)(A) [as amended by P.L. 100-485, §608(d)(4)], struck out "subsections (a) and (b)" and substituted "subsections (a) through (c)".

P.L. 101-234, §201(a)(1), struck out "subsections (a) through (c)" and substituted "subsections (a) and (b)", effective January 1, 1990.

[228] P.L. 101-239, §6113(d), struck out "whichever of the following amounts is the smaller:" and paragraphs (1) and (2), and substituted "62 1/2 percent of such expenses.", applicable to expenses incurred in a year beginning with 1990. [For paragraphs (1) and (2) as they formerly read, see Vol. III, P.L. 101-239.]

[229] P.L. 101-234, §201(a)(1), struck out "paragraph" and substituted "subsection", effective January 1, 1990.

[230] P.L. 101-234, §201(a)(1), redesignated paragraph (2) as subsection (d), effective January 1, 1990.

(f) In establishing limits under subsection (a) on payment for rural health clinic services provided by independent rural health clinics, the Secretary shall establish such limit, for services provided—

(1) in 1988, after March 31, at $46, and

(2) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) furnished as of the first day of that year.

(g) In the case of services described in the second sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than $750[231] shall be considered as incurred expenses for purposes of subsections (a) and (b)[232]. In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year, no more than $750[233] shall be considered as incurred expenses for purposes of subsections (a) and (b)[234].

(h)(1)(A) The Secretary shall establish fee schedules for clinical diagnostic laboratory tests for which payment is made under this part, other than such tests performed by a provider of services for an inpatient of such provider.

(B) In the case of clinical diagnostic laboratory tests performed by a physician or by a laboratory (other than tests performed by a qualified hospital laboratory (as defined in subparagraph (D)) for outpatients of such hospital), the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished on or after July 1, 1984.[235]

(C) In the case of clinical diagnostic laboratory tests performed by a qualified hospital laboratory (as defined in subparagraph (D)) for outpatients of such hospital, the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished on or after July 1, 1984.[236]

(D) In this subsection, the term "qualified hospital laboratory" means a hospital laboratory, in a sole community hospital (as defined in section 1886(d)(5)(D)(iii)[237]), which provides some clinical diagnostic laboratory tests 24 hours a day in order to serve a hospital emergency room which is available to provide services 24 hours a day and 7 days a week.

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[231] P.L. 101-239, §6133(a), struck out "$500" and substituted "$750", applicable to services furnished on or after January 1, 1990.

[232] P.L. 101-234, §201(a)(1), struck out "through (c)" and substituted "and (b)", effective January 1, 1990.

[233] P.L. 101-239, §6133(a), struck out "$500" and substituted "$750", applicable to services furnished on or after January 1, 1990.

[234] P.L. 100-360, §201(a)(3), struck out "and (b)" and substituted "through (c)", effective July 1, 1988.

P.L. 101-234, §201(a)(1), struck out "through (c)" and substituted "and (b)", effective January 1, 1990.

[235] P.L. 101-239, §6111(a)(1), struck out "during the period beginning on July 1, 1984, and ending on December 31, 1989. For such tests furnished on or after January 1, 1990, the fee schedule shall be established on a nationwide basis" and substituted "on or after July 1, 1984", effective December 19, 1989.

[236] P.L. 101-239, §6111(a)(1), struck out "during the period beginning on July 1, 1984, and ending on December 31, 1989. For such tests furnished on or after January 1, 1990, the fee schedule shall be established on a nationwide basis" and substituted "on or after July 1, 1984", effective December 19, 1989.

[237] P.L. 101-239, §6003(e)(2)(A), struck out "the last sentence of section 1886(d)(5)(C)(ii)" and substituted "section 1886(d)(5)(D)(iii)", effective December 19, 1989.

(2)(A)(i) Except as provided in paragraph (4), the Secretary shall set the fee schedules at 60 percent (or, in the case of a test performed by a qualified hospital laboratory (as defined in paragraph (1)(D)) for outpatients of such hospital, 62 percent) of the prevailing charge level determined pursuant to the third and fourth sentences of section 1842(b)(3) for similar clinical diagnostic laboratory tests for the applicable region, State, or area for the 12-month period beginning July 1, 1984, adjusted annually (to become effective on January 1 of each year) by a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average), and subject to such other adjustments as the Secretary determines are justified by technological changes.

(ii) Notwithstanding clause (i)[238]—

(I) any change in the fee schedules which would have become effective under this subsection for tests furnished on or after January 1, 1988, shall not be effective for tests furnished during the 3-month period beginning on January 1, 1988,[239]

(II) the Secretary shall not adjust the fee schedules under clause (i) to take into account any increase in the consumer price index for 1988, and[240]

(III) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1991, 1992, and 1993 shall be 2 percent.[241]

(iii) In establishing fee schedules under clause (i) with respect to automated tests and tests (other than cytopathology tests) which before July 1, 1984, the Secretary made subject to a limit based on lowest charge levels under the sixth sentence of section 1842(b)(3) performed after March 31, 1988, the Secretary shall reduce by 8.3 percent the fee schedules otherwise established for 1988, and such reduced fee schedules shall serve as the base for 1989 and subsequent years.

(B) The Secretary may make further adjustments or exceptions to the fee schedules to assure adequate reimbursement of (i) emergency laboratory tests needed for the provision of bona fide emergency services, and (ii) certain low volume high-cost tests where highly sophisticated equipment or extremely skilled personnel are necessary to assure quality.[242]

(3) In addition to the amounts provided under the fee schedules, the Secretary shall provide for and establish (A) a nominal fee to cover the appropriate costs in collecting the sample on which a clinical diagnostic laboratory test was performed and for which payment is made under this part, except that not more than one such fee may be provided under this paragraph with respect to samples collected in the same encounter, and (B) a fee to cover the

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[238] P.L. 101-508, §4154(a)(1), struck out "any other provision of this subsection" and substituted "clause (i)", effective November 5, 1990.

[239] P.L. 101-508, §4154(a)(2), struck out "and".

[240] P.L. 101-508, §4154(a)(3), struck out a period and substituted ", and".

[241] P.L. 101-508, §4154(a)(4), added subclause (III), effective November 5, 1990.

[242] See Vol. II, P.L. 100-203, §4064(b)(4), with respect to the responsibilities of the Comptroller General regarding fee schedules.

transportation and personnel expenses for trained personnel to travel to the location of an individual to collect the sample, except that such a fee may be provided only with respect to an individual who is homebound or an inpatient in an inpatient facility (other than a hospital). In establishing a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect a sample, the Secretary shall provide a method for computing the fee based on the number of miles traveled and the personnel costs associated with the collection of each individual sample, but the Secretary shall only be required to apply such method in the case of tests furnished during the period beginning on April 1, 1989, and ending on December 31, 1990, by a laboratory that establishes to the satisfaction of the Secretary (based on data for the 12-month period ending June 30, 1988) that (i) the laboratory is dependent upon payments under this title for at least 80 percent of its collected revenues for clinical diagnostic laboratory tests, (ii) at least 85 percent of its gross revenues for such tests are attributable to tests performed with respect to individuals who are homebound or who are residents in a nursing facility, and (iii) the laboratory provided such tests for residents in nursing facilities representing at least 20 percent of the number of such facilities in the State in which the laboratory is located.[243]

(4)(A) In establishing any fee schedule under this subsection, the Secretary may provide for an adjustment to take into account, with respect to the portion of the expenses of clinical diagnostic laboratory tests attributable to wages, the relative difference between a region's or local area's wage rates and the wage rate presumed in the data on which the schedule is based.

(B) For purposes of subsections (a)(1)(D)(i) and (a)(2)(D)(i), the limitation amount for a clinical diagnostic laboratory test performed—

(i) on or after July 1, 1986, and before April 1, 1988, is equal to 115 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),[244]

(ii) after March 31, 1988, and before January 1, 1990,[245] is equal to the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),[246]

(iii) after December 31, 1989, and before January 1, 1991,[247] is equal to 93 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1), and[248]

(iv) after December 31, 1990, is equal to 88 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1).[249]

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[243] See Vol. II, P.L. 100-647, §8421(b), with respect to budget neutrality; and §8421(c), with respect to a study and report to Congress on reimbursement for specimen collection and transportation and personnel costs.

[244] P.L. 101-239, §6111(a)(2), struck out "or".

[245] P.L. 101-239, §6111(a)(3)(A), struck out "and so long as a fee schedule for the test has not been established on a nationwide basis," and §6111(a)(3)(B) inserted "and before January 1, 1990,", effective December 19, 1989.

[246] P.L. 101-239, §6111(a)(3)(C), struck out the period and substituted ", and".

P.L. 101-508, §4154(b)(1)(A), struck out "and".

[247] P.L. 101-508, §4154(b)(1)(B)(i), inserted "and before January 1, 1991,", applicable to tests furnished on or after January 1, 1991.

[248] P.L. 101-239, §6111(a)(4), added clause (iii), effective December 19, 1989.

P.L. 101-508, §4154(b)(1)(B)(ii), struck out a period and substituted ", and".

[249] P.L. 101-508, §4154(b)(1)(C), added clause (iv), applicable to tests furnished on or after January 1, 1991.

(5)(A) In the case of a bill or request for payment for a clinical diagnostic laboratory test for which payment may otherwise be made under this part on an assignment-related basis or under a provider agreement under section 1866, payment may be made only to the person or entity which performed or supervised the performance of such test; except that—

(i) if a physician performed or supervised the performance of such test, payment may be made to another physician with whom he shares his practice,

(ii) in the case of a test performed at the request of a laboratory by another laboratory, payment may be made to the referring laboratory but only if—

(I) the referring laboratory is located in, or is part of, a rural hospital,

(II) the referring laboratory is wholly owned by[250] the entity performing such test, the referring laboratory wholly owns the entity performing such test, or both the referring laboratory and the entity performing such test are wholly-owned by a third entity, or

(III) not more than 30 percent of the clinical diagnostic laboratory tests for which such referring laboratory (but not including a laboratory described in subclause (II)),[251] receives requests for testing during the year in which the test is performed[252] are performed by another laboratory , and[253]

(iii) in the case of a clinical diagnostic laboratory test provided under an arrangement (as defined in section 1861(w)(1)) made by a hospital or rural primary care hospital,[254] payment shall be made to the hospital.[255]

(B) In the case of such a bill or request for payment for a clinical diagnostic laboratory test for which payment may otherwise be made under this part, and which is not described in subparagraph (A), payment may be made to the beneficiary only on the basis of the itemized bill of the person or entity which performed or supervised the performance of the test.

(C) Payment for a clinical diagnostic laboratory test, including a test performed in a physician's office but excluding a test performed by[256] a rural health clinic may only be made on an assignment-related basis or to a provider of services with an agreement in effect under section 1866.

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[250] P.L. 101-508, §4154(e)(1)(A), struck out "a wholly-owned subsidiary of" and substituted "wholly owned by", effective as if included in the enactment of P.L. 101-239.

[251] P.L. 101-508, §4154(e)(1)(B), inserted "(but not including a laboratory described in subclause (II)),", effective as if included in the enactment of P.L. 101-239. Executed as if amendment inserted material after "laboratory" in the second place it appears in subclause (III).

[252] P.L. 101-508, §4154(e)(1)(C), struck out "submits bills or requests for payment in any year" and substituted "receives requests for testing during the year in which the test is performed", effective January 1, 1991.

[253] P.L. 101-239, §6111(b)(1), struck out ", and" and substituted "but only if—" and subclauses (I)-(III), applicable with respect to clinical diagnostic laboratory tests performed on or after May[*] 1, 1990.

[*] P.L. 101-508, §4154(h)(4), struck out "January" and substituted "May", effective as if included in the enactment of P.L. 101-239.

[254] P.L. 101-239, §6003(g)(3)(D)(vii)(I), struck out "hospital," and substituted "hospital or rural primary care hospital,", effective December 19, 1989.

[255] Unable to execute P.L. 101-239, §6003(g)(3)(D)(vii)(I), here.

P.L. 101-508, §4008(m)(2)(C), struck out "each place it appears" in P.L. 101-239, §6003(g)(3)(C)(vii)(I). Executed as if P.L. 101-508, §4008(m)(2)(C), amended §6003(g)(3)(D)(vii)(I).

[256] P.L. 101-508, §4154(c)(1)(A), struck out "performed by a laboratory other than" and substituted ", including a test performed in a physician's office but excluding a test performed by", effective as if included in the enactment of P.L. 99-272.

(D) A person may not bill for a clinical diagnostic laboratory test, including a test performed in a physician's office but excluding a test performed by a rural health clinic,[257], other than on an assignment-related basis. If a person knowingly and willfully and on a repeated basis bills for a clinical diagnostic laboratory test in violation of the previous sentence, the Secretary may apply sanctions against the person in the same manner as the Secretary may apply sanctions against a physician in accordance with paragraphs (2) and (3) of section 1842(j) in the same manner such paragraphs apply with respect to a physician.

(6) In the case of any diagnostic laboratory test payment for which is not made on the basis of a fee schedule under paragraph (1), the Secretary may establish a payment rate which is acceptable to the person or entity performing the test and which would be considered the full charge for such tests. Such negotiated rate shall be limited to an amount not in excess of the total payment that would have been made for the services in the absence of such rate.[258]

(i)(1) The Secretary shall, in consultation with appropriate medical organizations—

(A) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in an ambulatory surgical center (meeting the standards specified under section 1832(a)(2)(F)(i)), rural primary care hospital,[259] or hospital outpatient department, and

(B) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in a physician's office.

The lists of procedures established under subparagraphs (A) and (B) shall be reviewed and updated not less often than every 2 years.

(2)(A) The amount of payment to be made for facility services furnished in connection with a surgical procedure specified pursuant to paragraph (1)(A) and furnished to an individual in an ambulatory surgical center described in such paragraph shall be equal to 80 percent of a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

(i) takes into account the costs incurred by such centers, or classes of centers, generally in providing services furnished in connection with the performance of such procedure,

(ii) takes such costs into account in such a manner as will assure that the performance of the procedure in such a center will result in substantially less amounts paid under this title than would have been paid if the procedure had been performed on an inpatient basis in a hospital, and

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[257] P.L. 101-508, §4154(c)(1)(B), struck out "performed by a laboratory, other than a rural health clinic" and substituted ", including a test performed in a physician's office but excluding a test performed by a rural health clinic,", effective as if included in the enactment of P.L. 100-203.

As in original; one comma should be stricken.

[258] See Vol. II, P.L. 100-203, §4064(a)(2), with respect to CPI increases in 1988.

[259] P.L. 101-239, §6003(g)(3)(D)(vii)(II), inserted ", rural primary care hospital,", effective December 19, 1989.

(iii) in the case of insertion of an intraocular lens during or subsequent to cataract surgery includes payment which is reasonable and related to the cost of acquiring the class of lens involved.[260]

Each amount so established shall be reviewed and updated not later than July 1, 1987, and annually thereafter and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

(B) The amount of payment to be made under this part for facility services furnished, in connection with a surgical procedure specified pursuant to paragraph (1)(B), in a physician's office shall be equal to 80 percent of a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

(i) takes into account additional costs, not usually included in the professional fee, incurred by physicians in securing, maintaining, and staffing the facilities and ancillary services appropriate for the performance of such procedure in the physician's office, and

(ii) takes such items into account in such a manner which will assure that the performance of such procedure in the physician's office will result in substantially less amounts paid under this title than would have been paid if the services had been furnished on an inpatient basis in a hospital.

Each amount so established shall be reviewed and updated not later than July 1, 1987, and annually thereafter and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

(3)(A) The aggregate amount of the payments to be made under this part for outpatient hospital facility services or rural primary care hospital services[261] furnished in connection with surgical procedures specified under paragraph (1)(A) in a cost reporting period shall be equal to the lesser of—

(i) the amount determined with respect to such services under subsection (a)(2)(B); or

(ii) the blend amount (described in subparagraph (B)).

(B)(i) The blend amount for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)(I)) of the amount described in subparagraph (A)(i), and

(II) the ASC proportion (as defined in clause (ii)(II)) of 80 percent of the standard overhead amount payable with respect to the same surgical procedure as if it were provided in an ambulatory surgical center in the same area, as determined under paragraph (2)(A).

(ii) Subject to the last sentence of this clause, in this paragraph:

(I) The term "cost proportion" means 75 percent for cost reporting periods beginning in fiscal year 1988, 50 percent for reporting periods beginning on or after October 1, 1988, and on or before December 31, 1990, and 42 percent for portions of cost reporting periods beginning on or after January 1, 1991.[262]

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[260] See Vol. II, P.L. 101-508, §4151(c)(3), with respect to the 2-year freeze in allowance for intraocular lenses.

[261] P.L. 101-239, §6003(g)(3)(D)(vii)(III), inserted "or rural primary care hospital services", effective December 19, 1989.

(II) The term "ASC proportion" means 25 percent for cost reporting periods beginning in fiscal year 1988, 50 percent for reporting periods beginning on or after October 1, 1988, and on or before December 31, 1990, and 58 percent for portions of cost reporting periods beginning on or after January 1, 1991.[263]

In the case of a hospital that makes application to the Secretary and demonstrates that it specializes in eye services or eye and ear services (as determined by the Secretary), receives more than 30 percent of its total revenues from outpatient services and was an eye specialty hospital or an eye and ear specialty hospital on October 1, 1987, the cost proportion and ASC proportion in effect under subclauses (I) and (II) for cost reporting periods beginning in fiscal year 1988 shall remain in effect for cost reporting periods beginning on or after October 1, 1988, and before January 1, 1995[264].

[(4) Stricken.[265]]

(5)(A) The Secretary is authorized to provide by regulations that in the case of a surgical procedure, specified by the Secretary pursuant to paragraph (1)(A), performed in an ambulatory surgical center described in such paragraph, there shall be paid (in lieu of any amounts otherwise payable under this part) with respect to the facility services furnished by such center and with respect to all related services (including physicians' services, laboratory, X-ray, and diagnostic services) a single all-inclusive fee established pursuant to subparagraph (B), if all parties furnishing all such services agree to accept such fee (to be divided among the parties involved in such manner as they shall have previously agreed upon) as full payment for the services furnished.

(B) In implementing this paragraph, the Secretary shall establish with respect to each surgical procedure specified pursuant to paragraph (1)(A) the amount of the all-inclusive fee for such procedure, taking into account such factors as may be appropriate. The amount so established with respect to any surgical procedure shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

(6) Any person, including a facility having an agreement under section 1832(a)(2)(F)(i), who knowingly and willfully presents, or causes to be presented, a bill or request for payment, for an intraocular lens inserted during or subsequent to cataract surgery for which payment may be made under paragraph (2)(A)(iii), is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

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[262] P.L. 101-508, §4151(c)(1)(A)(i), struck out "and 50 percent for other cost reporting periods." and substituted "50 percent for reporting periods beginning on or after October 1, 1988, and on or before December 31, 1990, and 42 percent for portions of cost reporting periods beginning on or after January 1, 1991.", effective November 5, 1990.

[263] P.L. 101-508, §4151(c)(1)(A)(ii), struck out "and 50 percent for other cost reporting periods." and substituted "50 percent for reporting periods beginning on or after October 1, 1988, and on or before December 31, 1990, and 58 percent for portions of cost reporting periods beginning on or after January 1, 1991.", effective November 5, 1990.

[264] P.L. 101-508, §4151(c)(1)(B), struck out "in fiscal year 1989 or fiscal year 1990" and substituted "on or after October 1, 1988, and before January 1, 1995", effective November 5, 1990.

[265] P.L. 100-203, §4054(a)(3), as amended by P.L. 100-360, §411(f)(12)(A), 102 Stat. 781.

(j) Whenever a final determination is made that the amount of payment made under this part either to a provider of services or to another person pursuant to an assignment under section 1842(b)(3)(B)(ii) was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments.

(k) With respect to services described in section 1861(s)(10)(B), the Secretary may provide, instead of the amount of payment otherwise provided under this part, for payment of such an amount or amounts as reasonably reflects the general cost of efficiently providing such services.

(l)(1)(A)[266] The Secretary shall establish a fee schedule for services of certified registered nurse anesthetists under section 1861(s)(11).

(B) In establishing the fee schedule under this paragraph the Secretary may utilize a system of time units, a system of base and time units, or any appropriate methodology.[267]

(C) The provisions of this subsection shall not apply to certain services furnished in certain hospitals in rural areas under the provisions of section 9320(k) of the Omnibus Budget Reconciliation Act of 1986[268], as amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989[269].[270]

(2) Except as provided in paragraph (3), the fee schedule established under paragraph (1) shall be initially based on audited data from cost reporting periods ending in fiscal year 1985 and such other data as the Secretary determines necessary.[271]

(3)(A) In establishing the initial fee schedule for those services, the Secretary shall adjust the fee schedule to the extent necessary to ensure that the estimated total amount which will be paid under this title for those services plus applicable coinsurance in 1989 will equal the estimated total amount which would be paid under this title for those services in 1989 if the services were included as inpatient hospital services and payment for such services was made under part A in the same manner as payment was made in fiscal year 1987, adjusted to take into account changes in prices and technology relating to the administration of anesthesia.

(B) The Secretary shall also reduce the prevailing charge of physicians for medical direction of a certified registered nurse anesthetist, or the fee schedule for services of certified registered nurse anesthetists, or both, to the extent necessary to ensure that the estimated total amount which will be paid under this title plus applicable coinsurance for such medical direction and such services in 1989 and 1990 will not exceed the estimated total amount which would have been paid plus applicable coinsurance but for the enactment of the amendments made by section 9320 of the Omnibus Budget Reconciliation Act of 1986[272]. A reduced prevailing charge under this subparagraph shall become the prevailing charge but for subsequent years for purposes of applying the economic index under the fourth sentence of section 1842(b)(3).

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[266] P.L. 101-508, §4160(1)(A), redesignated paragraph (1) as subparagraph (A), effective November 5, 1990.

[267] P.L. 101-508, §4160(1)(B), added subparagraph (B), effective November 5, 1990.

[268] P.L. 99-509.

[269] P.L. 101-239.

[270] P.L. 101-508, §4160(1)(B), added subparagraph (C), effective November 5, 1990.

[271] P.L. 101-508, §4160(2), struck out "The fee schedule shall be adjusted annually (to become effective on January 1 of each calendar year) by the percentage increase in the MEI (as defined in section 1842(i)(3)) for that year.", effective November 5, 1990.

(4)(A) Except as provided in subparagraphs (C) and (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, by a certified registered nurse anesthetist who is not medically directed—

(i) the conversion factor shall be—

(I) for services furnished in 1991, $15.50,

(II) for services furnished in 1992, $15.75,

(III) for services furnished in 1993, $16.00,

(IV) for services furnished in 1994, $16.25,

(V) for services furnished in 1995, $16.50,

(VI) for services furnished in 1996, $16.75, and

(VII) for services furnished in calendar years after 1996, the previous year's conversion factor increased by the update determined under section 1848(d)(3) for physician anesthesia services for that year;

(ii) the payment areas to be used shall be the fee schedule areas used under section 1848 (or, in the case of services furnished during 1991, the localities used under section 1842(b)) for purposes of computing payments for physicians' services that are anesthesia services;

(iii) the geographic adjustment factors to be applied to the conversion factor under clause (i) for services in a fee schedule area or locality is—

(I) in the case of services furnished in 1991, the geographic work index value and the geographic practice cost index value specified in section 1842(q)(1)(B) for physicians' services that are anesthesia services furnished in the area or locality, and

(II) in the case of services furnished after 1991, the geographic work index value, the geographic practice cost index value, and the geographic malpractice index value used for determining payments for physicians' services that are anesthesia services under section 1848,

with 70 percent of the conversion factor treated as attributable to work and 30 percent as attributable to overhead for services furnished in 1991 (and the portions attributable to work, practice expenses, and malpractice expenses in 1992 and thereafter being the same as is applied under section 1848).

(B)(i) Except as provided in clause (ii) and subparagraph (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, by a certified registered nurse anesthetist who is medically directed, the Secretary shall apply the same methodology specified in subparagraph (A).

(ii) The conversion factor used under clause (i) shall be—

(I) for services furnished in 1991, $10.50,

(II) for services furnished in 1992, $10.75,

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[272] P.L. 99-509.

(III) for services furnished in 1993, $11.00,

(IV) for services furnished in 1994, $11.25,

(V) for services furnished in 1995, $11.50,

(VI) for services furnished in 1996, $11.70, and

(VII) for services furnished in calendar years after 1997, the previous year's conversion factor increased by the update determined under section 1848(d)(3) for physician anesthesia services for that year.

(C) Notwithstanding subclauses (I) through (V) of subparagraph (A)(i)—

(i) in the case of a 1990 conversion factor that is greater than $16.50, the conversion factor for a calendar year after 1990 and before 1996 shall be the 1990 conversion factor reduced by the product of the last digit of the calendar year and one-fifth of the amount by which the 1990 conversion factor exceeds $16.50; and

(ii) in the case of a 1990 conversion factor that is greater than $15.49 but less than $16.51, the conversion factor for a calendar year after 1990 and before 1996 shall be the greater of—

(I) the 1990 conversion factor, or

(II) the conversion factor specified in subparagraph (A)(i) for the year involved.

(D) Notwithstanding subparagraph (C), in no case may the conversion factor used to determine payment for services in a fee schedule area or locality under this subsection, as adjusted by the adjustment factors specified in subparagraphs[273] (A)(iii), exceed the conversion factor used to determine the amount paid for physicians' services that are anesthesia services in the area or locality.[274]

(5)(A) Payment for the services of a certified registered nurse anesthetist (for which payment may otherwise be made under this part) may be made on the basis of a claim or request for payment presented by the certified registered nurse anesthetist furnishing such services, or by a hospital, rural primary care hospital,[275] physician, group practice, or ambulatory surgical center with which the certified registered nurse anesthetist furnishing such services has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, rural primary care hospital,[276] physician, group practice, or ambulatory surgical center.

(B)(i) Payment for the services of a certified registered nurse anesthetist under this part may be made only on an assignment-related basis, and any such assignment agreed to by a certified registered nurse anesthetist shall be binding upon any other person presenting a claim or request for payment for such services.

(ii) Except for deductible and coinsurance amounts applicable under this section, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services of a certified registered nurse anesthetist for which payment may be made under this part only on an assignment-related basis is subject to a civil money penalty of not to exceed $2,000 for each such bill or request. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

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[273] Probably should be "subparagraph".

[274] P.L. 101-508, §4160(3), amended paragraph (4) in its entirety, effective November 5, 1990. [For paragraph (4) as it formerly read, see Vol III, P.L. 101-508.]

[275] P.L. 101-239, §6003(g)(3)(D)(vii)(IV), inserted "rural primary care hospital,", effective December 19, 1990.

[276] P.L. 101-239, §6003(g)(3)(D)(vii)(IV), inserted "rural primary care hospital,", effective December 19, 1990.

(C) No hospital or rural primary care hospital[277] that presents a claim or request for payment for services of a certified nurse anesthetist under this part may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital or rural primary care hospital[278] for purposes of this title.

(6) If an adjustment under paragraph (3)(B) results in a reduction in the reasonable charge for a physicians' service and a nonparticipating physician furnishes the service to an individual entitled to benefits under this part after the effective date of the reduction, the physician's actual charge is subject to a limit under section 1842(j)(1)(D).[279]

(m) In the case of physicians' services furnished to an individual, who is covered under the insurance program established by this part and who incurs expenses for such services, in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act[280]) as a[281] health professional[282] shortage area, in addition to the amount otherwise paid under this part, there also shall be paid to the physician (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal to 10[283] percent of the payment amount for the service under this part.[284]

(n)(1)(A) The aggregate amount of the payments to be made for all or part of a cost reporting period for services described in subsection (a)(2)(E)(i) furnished under this part on or after October 1, 1988, and for services described in subsection (a)(2)(E)(ii) furnished under this part on or after October 1, 1989, shall be equal to the lesser of—

(i) the amount determined with respect to such services under subsection (a)(2)(B), or

(ii) the blend amount for radiology services and diagnostic procedures determined in accordance with subparagraph (B).

(B)(i) The blend amount for radiology services and diagnostic procedures for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)) of the amount described in subparagraph (A)(i); and

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[277] P.L. 101-239, §6003(g)(3)(D)(vii)(V), inserted "or rural primary care hospital", effective December 19, 1990.

[278] P.L. 101-239, §6003(g)(3)(D)(vii)(V), inserted "or rural primary care hospital", effective December 19, 1990.

[279] P.L. 99-509, §9320(e)(2), added subsection (l). For the effective date, see Vol. II, P.L. 99-509, §9320(i), as amended by P.L. 100-485.

[280] P.L. 78-410.

[281] P.L. 101-239, §6102(c)(1)(A), struck out "class 1 or class 2", applicable to services furnished on or after January 1, 1991.

[282] P.L. 101-597, §401(c)(2), struck out "manpower" and substituted "professional", effective November 16, 1990.

[283] P.L. 101-239, §6102(c)(1)(B), struck out "5" and substituted "10", applicable to services furnished on or after January 1, 1991.

[284] P.L. 100-203, §4043(a), added subsection (m), applicable with respect to services furnished in a rural area (as defined in section 1886(d)(2)(D)) on or after January 1, 1989, and to other services furnished on or after January 1, 1991.

Effective November 5, 1990, P.L. 101-508, §4118(g)(1), repealed P.L. 100-203, §4043(b), which required the Secretary to make a study and report to Congress.

(II) the charge proportion (as defined in clause (ii)(II)) of 62 percent (for services described in subsection (a)(2)(E)(i)), or (for procedures described in subsection (a)(2)(E)(ii)), 42 percent or such other percent established by the Secretary (or carriers acting pursuant to guidelines issued by the Secretary) based on prevailing charges established[285] with actual charge data, of 80 percent of the prevailing charge or (for services described in subsection (a)(2)(E)(i) furnished on or after January 1, 1989) the fee schedule amount established for participating physicians for the same services as if they were furnished in a physician's office in the same locality as determined under section 1842(b).

(ii) In this subparagraph:

(I) The term "cost proportion" means 50 percent, except that such term means 65 percent in the case of outpatient radiology services for portions of cost reporting periods which occur in fiscal year 1989 and in the case of diagnostic procedures described in subsection (a)(2)(E)(ii) for portions of cost reporting periods which occur in fiscal year 1990, and such term means 42 percent in the case of outpatient radiology services for portions of cost reporting periods beginning on or after January 1, 1991.[286]

(II) The term "charge proportion" means 100 percent minus the cost proportion.[287] [288]

(o)(1) In the case of shoes described in section 1861(s)(12)—

(A) no payment may be made under this part, with respect to any individual for any year, for the furnishing of—

(i) more than one pair of custom molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts for such shoes, or

(ii) more than one pair of extra-depth shoes (not including inserts provided with such shoes) and 3 pairs of inserts for such shoes, and[289]

(B) with respect to expenses incurred in any calendar year, no more than the limits[290] established under paragraph (2) shall be considered as incurred expenses for purposes of subsections (a) and (b).

Payment for shoes (or inserts)[291] under this part shall be considered to include payment for any expenses for the fitting of such shoes (or inserts)[292].

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[285] P.L. 100-360, §411(g)(4)(C)(ii), inserted "or (for services described in subsection (a)(2)(E)(i) furnished on or after January 1, 1989) the fee schedule amount established", effective as if included in the enactment of P.L. 100-203.

[286] P.L. 100-360, §411(g)(4)(C)(iii), amended this subclause in its entirety, effective as if included in the enactment of P.L. 100-203. [For this subclause as it formerly read, see Vol. III, P.L. 100-360.]

P.L. 101-508, §4151(c)(2), struck out a period and substituted ", and such term means 42 percent in the case of outpatient radiology services for portions of cost reporting periods beginning on or after January 1, 1991.", effective November 5, 1990.

[287] P.L. 100-360, §411(g)(4)(C)(iii), amended this subclause in its entirety, effective as if included in the enactment of P.L. 100-203. [For this subclause as it formerly read, see Vol. III, P.L. 100-360.]

[288] P.L. 100-203, §4066(a)(2), added subsection (n), applicable with respect to outpatient hospital radiology services furnished on or after October 1, 1988, and other diagnostic procedures performed on or after October 1, 1989.

[289] P.L. 101-239, §6131(a)(1)(A), amended subparagraph (A) in its entirety, applicable with respect to therapeutic shoes and inserts furnished on or after July 1, 1989. In applying this amendment, the increase under §1833(o)(2)(C) shall apply to the dollar amounts specified under §1833(o)(2)(A) (as amended) in the same manner as the increase would have applied to the dollar amounts specified under §1833(o)(2)(A) (as in effect before December 19, 1989). [For subparagraph (A) as it formerly read, see Vol. III, P.L. 101-239.]

[290] P.L. 101-239, §6131(a)(1)(B), struck out "limit" and substituted "limits", applicable as the amendment made by §6131(a)(1)(A).

[291] P.L. 101-239, §6131(a)(1)(C), inserted "(or inserts)", applicable as the amendment made by §6131(a)(1)(A).

(2)(A) Except as provided by the Secretary under subparagraphs (B) and (C), the limits[293] established under this paragraph—

(i) for the furnishing of—

(I) one pair of custom molded shoes (including any inserts that are provided initially with the shoes) is $300, and

(II) any additional pair of inserts with respect to such shoes is $50; and[294]

(ii) for the furnishing of extra-depth shoes and inserts is—

(I) $100 for the pair of shoes itself, and

(II) $50 for any pairs of[295] inserts for a pair of shoes.

(B) The Secretary or a carrier may establish limits for shoes that are lower than the limits established under subparagraph (A) if the Secretary finds that shoes and inserts of an appropriate quality are readily available at or below such lower limits.

(C) For each year after 1988, each dollar amount under subparagraph (A) or (B) (as previously adjusted under this subparagraph) shall be increased by the same percentage increase as the Secretary provides with respect to durable medical equipment for that year, except that if such increase is not a multiple of $1, it shall be rounded to the nearest multiple of $1.

(D) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1861(s)(12) may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pairs[296] of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall substitute, for the limits established under subparagraph (A), such limits as the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this subparagraph.[297]

(3) In this title, the term "shoes" includes, except for purposes of subparagraphs (A)(ii) and (B) of paragraph (2), inserts for extra-depth shoes.[298]

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[292] P.L. 101-239, §6131(a)(1)(C), inserted "(or inserts)", applicable as the amendment made by §6131(a)(1)(A).

[293] P.L. 101-239, §6131(a)(1)(B), struck out "limit" and substituted "limits", applicable as the amendment made by §6131(a)(1)(A).

[294] P.L. 101-239, §6131(a)(1)(D), amended clause (i) in its entirety, applicable as the amendment made by §6131(a)(1)(A). [For clause (i) as it formerly read, see Vol. III, P.L. 101-239.]

[295] P.L. 101-239, §6131(a)(1)(E), inserted "any pairs of", applicable as the amendment made by §6131(a)(1)(A).

[296] As in original.

[297] P.L. 101-239, §6131(b), added subparagraph (D), applicable as the amendment made by §6131(a)(1)(A).

[298] P.L. 100-203, §4072(b), added this subsection. P.L. 100-203, §4072(e), reads as follows:

"(e) CONTINGENT EFFECTIVE DATE; DEMONSTRATION PROJECT.—

"(1) The amendments made by this section shall become effective (if at all) in accordance with paragraph (2).

"(2)(A) The Secretary of Health and Human Services (in this paragraph referred to as the 'Secretary'), shall establish a demonstration project to begin on October 1, 1988, to test the cost-effectiveness of furnishing therapeutic shoes under the medicare program to the extent provided under the amendments made by this section to a sample group of medicare beneficiaries.

"(B)(i) The demonstration project under subparagraph (A) shall be conducted for an initial period of 24 months. Not later than October 1, 1990, the Secretary shall report to the Congress on the results of such project. If the Secretary finds, on the basis of existing data, that furnishing therapeutic shoes under the medicare program to the extent provided under the amendments made by this section is cost-effective, the Secretary shall include such finding in such report, such project shall be discontinued, and the amendments made by this section shall become effective on November 1, 1990.

"(ii) If the Secretary determines that such finding cannot be made on the basis of existing

(p) In the case of certified nurse-midwife services for which payment may be made under this part only pursuant to section 1861(s)(2)(L),[299] in the case of qualified psychologists services for which payment may be made under this part only pursuant to section 1861(s)(2)(M), and in the case of clinical social worker services for which payment may be made under this part only pursuant to section 1861(s)(2)(N),[300] payment may only be made under this part for such services on an assignment-related basis. Except for deductible and coinsurance amounts applicable under section 1833, whoever knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in the previous sentence, is subject to a civil money penalty of not to exceed $2,000 for each such bill or request. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(q)(1) Each request for payment, or bill submitted, for an item or service furnished by an entity for which payment may be made under this part and for which the entity knows or has reason to believe there has been a referral by a referring physician (within the meaning of section 1877) shall include the name and provider number for the referring physician and indicate whether or not the referring physician is an interested investor (within the meaning of section 1877(h)(5)).

(2)(A) In the case of a request for payment for an item or service furnished by an entity under this part on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included, payment may be denied under this part.

(B) In the case of a request for payment for an item or service furnished by an entity under this part not submitted on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included—

(i) if the entity knowingly and willfully fails to provide such information promptly upon request of the Secretary or a carrier, the entity may be subject to a civil money penalty in an amount not to exceed $2,000, and

(ii) if the entity knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection to provide the information required under paragraph (1), the entity may be subject to exclusion from participation in the programs under this Act for

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data, such project shall continue for an additional 24 months. Not later than April 1, 1993, the Secretary shall submit a final report to the Congress on the results of such project. The amendments made by this section shall become effective on the first day of the first month to begin after such report is submitted to the Congress unless the report contains a finding by the Secretary that furnishing therapeutic shoes under the medicare program to the extent provided under the amendments made by this section is not cost-effective (in which case the amendments made by this section shall not become effective).".

P.L. 100-360, §411(h)(3)(B)(iii) [as redesignated by P.L. 100-485, §608(d)(23)(A)], amended P.L. 100-203, §4072(b), by redesignating this subsection as subsection (o), effective as if included in the enactment of P.L. 100-203, §4072(b).

[299] P.L. 101-239, §6113(b)(3)(B)(i), struck out "and" and substituted a comma.

[300] P.L. 101-239, §6113(b)(3)(B)(ii), inserted "and in the case of clinical social worker services for which payment may be made under this part only pursuant to section 1861(s)(2)(N),", applicable to services furnished on or after July 1, 1990.

a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1128.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under clause (i) in the same manner as they apply to a penalty or proceeding under section 1128A(a).[301]

(r)(1) With respect to services described in section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area), payment may be made on the basis of a claim or request for payment presented by the nurse practitioner or clinical nurse specialist furnishing such services, or by a hospital, rural primary care hospital, skilled nursing facility or nursing facility (as defined in section 1919(a)), physician, group practice, ambulatory surgical center, with which the nurse practitioner or clinical nurse specialist has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, physician, group practice,[302] ambulatory surgical center.

(2)(A) For purposes of subsection (a)(1)(M), the prevailing charge for services described in section 1861(s)(2)(K)(iii) may not exceed the applicable percentage (as defined in subparagraph (B)) of the prevailing charge (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) determined for such services performed by physicians who are not specialists.

(B) In subparagraph (A), the term "applicable percentage" means—

(i) 75 percent in the case of services performed in a hospital, and

(ii) 85 percent in the case of other services.

(3)(A) Payment under this part for services described in section 1861(s)(2)(K)(iii) may be made only on an assignment-related basis, and any such assignment agreed to by a nurse practitioner or clinical nurse specialist shall be binding upon any other person presenting a claim or request for payment for such services.

(B) Except for deductible and coinsurance amounts applicable under this section, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in section 1861(s)(2)(K)(iii) in violation of subparagraph (A) is subject to a civil money penalty of not to exceed $2,000 for each such bill or request. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(4) No hospital or rural primary care hospital that presents a claim or request for payment under this part for services described in section 1861(s)(2)(K)(iii) may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital for purposes of this title.[303]

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[301] P.L. 101-239, §6204(b), added subsection (q), effective with respect to referrals made on or after January 1, 1992.

[302] As in original; probably should read ", or".

[303] P.L. 101-508, §4155(b)(3), added subsection (r), applicable to services furnished on or after January 1, 1991.

(r) The Secretary may not provide for payment under subsection (a)(1)(A) with respect to an organization unless the organization provides assurances satisfactory to the Secretary that the organization meets the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).[304]

SPECIAL PAYMENT RULES FOR PARTICULAR ITEMS AND SERVICES

SEC. 1834. [42 U.S.C. 1395m] (a) PAYMENT FOR DURABLE MEDICAL EQUIPMENT[305].—

(1) GENERAL RULE FOR PAYMENT.—

(A) IN GENERAL.—With respect to a covered item (as defined in paragraph (13)) for which payment is determined under this subsection, payment shall be made in the frequency specified in paragraphs (2) through (7) and in an amount equal to 80 percent of the payment basis described in subparagraph (B).

(B) PAYMENT BASIS.—The payment basis described in this subparagraph is the lesser of—

(i) the actual charge for the item, or

(ii) the payment amount recognized under paragraphs (2) through (7) of this subsection for the item;

except that clause (i) shall not apply if the covered item is furnished by a public home health agency (or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low income) free of charge or at nominal charges to the public.

(C) EXCLUSIVE PAYMENT RULE.—This subsection shall constitute the exclusive provision of this title for payment for covered items under this part or under part A to a home health agency.

(D) REDUCTION IN FEE SCHEDULES FOR CERTAIN ITEMS.—With respect to a seat-lift chair or transcutaneous electrical nerve stimulator furnished on or after April 1, 1990, the Secretary shall reduce the payment amount applied under subparagraph (B)(ii) for such an item by 15 percent, and, in the case of a transcutaneous electrical nerve stimulator furnished on or after January 1, 1991, the Secretary shall further reduce such payment amount (as previously reduced) by 15 percent[306].[307]

(2) PAYMENT FOR INEXPENSIVE AND OTHER ROUTINELY PURCHASED DURABLE MEDICAL EQUIPMENT.—

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[304] P.L. 101-508, §4206(b)(2), added a second subsection (r), applicable to contracts under §1876 and payments under §1833(a)(1)(A) as of December 1, 1991.

See Vol. II, P.L. 101-508, §4206(c), with respect to the effect on State law.

[305] P.L. 100-203, §4062 [as amended by P.L. 101-508, §4152(h)], added this subsection, applicable to covered items (other than oxygen and oxygen equipment) furnished on or after January 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989.

P.L. 101-508, §4153(a)(2)(D)(i), struck out ", PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS", applicable to items furnished on or after January 1, 1991.

See Vol. II, P.L. 101-508, §4153(c), with respect to a GAO study of medicare payments for prosthetic devices, orthotics, and prosthetics.

[306] P.L. 101-508, §4152(a)(1), inserted ", and, in the case of a transcutaneous electrical nerve stimulator furnished on or after January 1, 1991, the Secretary shall further reduce such payment amount (as previously reduced) by 15 percent", applicable to items furnished on or after January 1, 1991.

[307] P.L. 101-239, §6112(c), added subparagraph (D), effective December 19, 1989.

(A) In general.—Payment for an item of durable medical equipment (as defined in paragraph (13)[308])—

(i) the purchase price of which does not exceed $150, or[309]

(ii) which the Secretary determines is acquired at least 75 percent of the time by purchase,[310]

[(iii) Stricken.[311]]

shall be made on a rental basis or in a lump-sum amount for the purchase of the item. The payment amount recognized for purchase or rental of such equipment is the amount specified in subparagraph (B) for purchase or rental, except that the total amount of payments with respect to an item may not exceed the payment amount specified in subparagraph (B) with respect to the purchase of the item.

(B) Payment amount.—For purposes of subparagraph (A), the amount specified in this subparagraph, with respect to the purchase or rental of an item furnished in a carrier service area—

(i) in 1989 and in 1990[312] is the average reasonable charge in the area for the purchase or rental, respectively, of the item for the 12-month period ending on June 30, 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987;[313]

(ii) in 1991 is the sum of (I) 67 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(I) for 1991, and (II) 33 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1991;[314]

(iii) in 1992 is the sum of (I) 33 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(II) for 1992, and (II) 67 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1992; and[315]

(iv) in 1993 and each subsequent year is the national limited payment amount for the item or device computed under subparagraph (C)(ii) for that year.[316]

(C) Computation of local payment amount and national limited payment amount.—For purposes of subparagraph (B)—

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[308] P.L. 101-508, §4153(a)(2)(D)(ii), struck out "(A)", applicable to items furnished on or after January 1, 1991.

[309] P.L. 101-239, §6112(d)(1)(A), struck out "or".

P.L. 101-508, §4152(c)(4)(A)(i), inserted "or".

[310] P.L. 101-239, §6112(d)(1)(B), added "or".

P.L. 101-508, §4152(c)(4)(A)(ii), struck out "or".

[311] P.L. 101-239, §6112(d)(1)(C), added clause (iii), effective December 19, 1989.

P.L. 101-508, §4152(c)(4)(A)(iii), struck out clause (iii), applicable to items furnished on or after January 1, 1991. [For clause (iii) as it formerly read, see Vol. III, P.L. 101-508.]

[312] P.L. 101-239, §6112(a)(1), inserted "and in 1990", effective December 19, 1989.

[313] P.L. 101-508, §4152(b)(1)(A), struck out "or".

[314] P.L. 101-508, §4152(b)(1)(B), amended clause (ii) in its entirety, applicable to items furnished on or after January 1, 1991. [For clause (ii) as it formerly read, see Vol. III, P.L. 101-508.]

[315] P.L. 101-508, §4152(b)(1)(B), added clause (iii), applicable to items furnished on or after January 1, 1991.

[316] P.L. 101-508, §4152(b)(1)(B), added clause (iv), applicable to items furnished on or after January 1, 1991.

(i) the local payment amount for an item or device for a year is equal to—

(I) for 1991, the amount specified in subparagraph (B)(i) for 1990 increased by the covered item update for 1991, and

(II) for 1992, the amount determined under this clause for the preceding year increased by the covered item update for 1992; and

(ii) the national limited payment amount for an item or device for a year is equal to—

(I) for 1991, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exeed 100 percent of the weighted average of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the weighted average of all local payment amounts determined under such clause for such item, and

(II) for each subsequent year, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year.[317]

(3) PAYMENT FOR ITEMS REQUIRING FREQUENT AND SUBSTANTIAL SERVICING.—

(A) IN GENERAL.—Payment for a covered item (such as ventilators, aspirators, IPPB machines, and nebulizers) for which there must be frequent and substantial servicing in order to avoid risk to the patient's health shall be made on a monthly basis for the rental of the item and the amount recognized is the amount specified in subparagraph (B).

(B) PAYMENT AMOUNT.—For purposes of subparagraph (A), the amount specified in this subparagraph, with respect to an item or device furnished in a carrier service area—

(i) in 1989 and in 1990[318] is the average reasonable charge in the area for the rental of the item or device for the 12-month period ending with June 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987;[319]

(ii) in 1991 is the sum of (I) 67 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(I) for 1991, and (II) 33 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1991;[320]

(iii) in 1992 is the sum of (I) 33 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(II) for 1992, and (II) 67 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1992; and[321]

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[317] P.L. 101-508, §4152(b)(1)(C), added subparagraph (C), applicable to items furnished on or after January 1, 1991.

[318] P.L. 101-239, §6112(a)(1), inserted "and in 1990", effective December 19, 1989.

[319] P.L. 101-508, §4152(b)(1)(A), struck out "or".

[320] P.L. 101-508, §4152(b)(1)(B), amended clause (ii) in its entirety, applicable to items furnished on or after January 1, 1991. [For clause (ii) as it formerly read, see Vol. III, P.L. 101-508.]

(iv) in 1993 and each subsequent year is the national limited payment amount for the item or device computed under subparagraph (C)(ii) for that year.[322]

(C) COMPUTATION OF LOCAL PAYMENT AMOUNT AND NATIONAL LIMITED PAYMENT AMOUNT.—For purposes of subparagraph (B)—

(i) the local payment amount for an item or device for a year is equal to—

(I) for 1991, the amount specified in subparagraph (B)(i) for 1990 increased by the covered item update for 1991, and

(II) for 1992, the amount determined under this clause for the preceding year increased by the covered item update for 1992; and

(ii) the national limited payment amount for an item or device for a year is equal to—

(I) for 1991, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exeed 100 percent of the weighted average of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the weighted average of all local payment amounts determined under such clause for such item, and

(II) for each subsequent year, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year.[323]

(D) REPLACEMENT OF ITEMS.—If the reasonable useful lifetime of such an item, as established under paragraph (7)(C), has been reached during a continuous period of medical need, or the Secretary determines on the basis of investigation by the carrier that the item is lost or irreparably damaged, payment for an item serving as a replacement for such item shall be made on a monthly basis for the rental of the replacement item in accordance with subparagraph (A).[324]

(4) PAYMENT FOR CERTAIN CUSTOMIZED ITEMS.—Payment with respect to a covered item that is uniquely constructed or substantially modified to meet the specific needs of an individual patient, and for that reason cannot be grouped with similar items for purposes of payment under this title, shall be made in a lump-sum amount (A) for the purchase of the item in a payment amount based upon the carrier's individual consideration for that item, and (B) for the reasonable and necessary maintenance and servicing for parts and labor not covered by

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[321] P.L. 101-508, §4152(b)(1)(B), added clause (iii), applicable to items furnished on or after January 1, 1991.

[322] P.L. 101-508, §4152(b)(1)(B), added clause (iv), applicable to items furnished on or after January 1, 1991.

[323] P.L. 101-508, §4152(b)(1)(C), added subparagraph (C), applicable to items furnished on or after January 1, 1991.

[324] P.L. 101-508, §4152(c)(3), added subparagraph (D), applicable to items furnished on or after January 1, 1991.

the supplier's or manufacturer's warranty, when necessary during the period of medical need, and the amount recognized for such maintenance and servicing shall be paid on a lump-sum, as needed basis based upon the carrier's individual consideration for that item. In the case of a wheelchair furnished on or after January 1, 1992, the wheelchair shall be treated as a customized item for purposes of this paragraph if the wheelchair has been measured, fitted, or adapted in consideration of the patient's body size, disability, period of need, or intended use, and has been assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs that are intended for an individual patient's use in accordance with instructions from the patient's physician.[325]

(5) PAYMENT FOR OXYGEN AND OXYGEN EQUIPMENT.—

(A) IN GENERAL.—Payment for oxygen and oxygen equipment shall be made on a monthly basis in the monthly payment amount recognized under paragraph (9) for oxygen and oxygen equipment (other than portable oxygen equipment), subject to subparagraphs (B), (C), and (E)[326].

(B) ADD-ON FOR PORTABLE OXYGEN EQUIPMENT.—When portable oxygen equipment is used, but subject to subparagraph (D), the payment amount recognized under subparagraph (A) shall be increased by the monthly payment amount recognized under paragraph (9) for portable oxygen equipment.

(C) VOLUME ADJUSTMENT.—When the attending physician prescribes an oxygen flow rate—

(i) exceeding 4 liters per minute, the payment amount recognized under subparagraph (A), subject to subparagraph (D), shall be increased by 50 percent, or

(ii) of less than 1 liter per minute, the payment amount recognized under subparagraph (A) shall be decreased by 50 percent.

(D) LIMIT ON ADJUSTMENT.—When portable oxygen equipment is used and the attending physician prescribes an oxygen flow rate exceeding 4 liters per minute, there shall only be an increase under either subparagraph (B) or (C), whichever increase is larger, and not under both such subparagraphs.

(E) RECERTIFICATION FOR PATIENTS RECEIVING HOME OXYGEN THERAPY.—In the case of a patient receiving home oxygen therapy services who, at the time such services are initiated, has an initial arterial blood gas value at or above a partial pressure of 55 or an arterial oxygen saturation at or above 89 percent (or such other values, pressures, or criteria as the Secretary may specify) no payment may be made under this part for such services after the expiration of the 90-day period that begins on the date the patient first receives such services unless the patient's attending physician certifies that, on the basis of a follow-up test of the patient's arterial blood gas value or arterial oxygen saturation conducted during the final 30 days of such 90-day period, there is a medical need for the patient to continue to receive such services.[327]

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[325] P.L. 101-239, §6112(d)(2), requires the Secretary by regulation to specify criteria to be used by carriers in making determinations on a case-by-case basis as whether to classify power-driven wheelchairs as a customized item (as described in this paragraph) for purposes of reimbursement under title XVIII.

P.L. 101-508, §4152(c)(4)(B)(i), added this sentence, applicable to items furnished on or after January 1, 1992, unless the Secretary develops specific criteria before that date for the treatment of wheelchairs as customized items for purposes of this paragraph (in which case this amendment shall not become effective).

[326] P.L. 101-508, §4152(g)(1)(A), struck out "(B) and (C)" and substituted "(B), (C), and (E)", applicable to patients who first receive home oxygen therapy services on or after January 1, 1991.

(6) PAYMENT FOR OTHER COVERED ITEMS (OTHER THAN DURABLE MEDICAL EQUIPMENT).—Payment for other covered items (other than durable medical equipment and other covered items described in paragraph (3), (4), or (5)) shall be made in a lump-sum amount for the purchase of the item in the amount of the purchase price recognized under paragraph (8).

(7) PAYMENT FOR OTHER ITEMS OF DURABLE MEDICAL EQUIPMENT.—

(A) IN GENERAL.—In the case of an item of durable medical equipment not described in paragraphs (2) through (6)—

(i) payment shall be made on a monthly basis for the rental of such item during the period of medical need (but payments under this clause[328] may not extend over a period of continuous use of longer than 15 months, or, in the case of an item for which a purchase agreement has been entered into under clause (iii), a period of continuous use of longer than 13 months[329]), and, subject to subparagraph (B), the amount recognized for each of the first 3 months of such period[330] is 10 percent of the purchase price recognized under paragraph (8) with respect to the item, and for each of the remaining months of such period is 7.5 percent of such purchase price[331];

(ii) in the case of a power-driven wheelchair, at the time the supplier furnishes the item, the supplier shall offer the individual patient the option to purchase the item, and payment for such item shall be made on a lump-sum basis if the patient exercises such option;[332]

(iii) during the 10th continuous month during which payment is made for the rental of an item under clause (i), the supplier of such item shall offer the individual patient the option to enter into a purchase agreement under which, if the patient notifies the supplier not later than 1 month after the supplier makes such offer that the patient agrees to accept such offer and exercise such option—

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[327] P.L. 101-508, §4152(g)(1)(B), added subparagraph (E), applicable to patients who first receive home oxygen therapy services on or after January 1, 1991.

[328] P.L. 101-239, §6112(a)(4)(A), struck out "subparagraph" and substituted "clause", effective December 19, 1989.

[329] P.L. 101-508, §4152(c)(2)(A), inserted ", or, in the case of an item for which a purchase agreement has been entered into under clause (iii), a period of continuous use of longer than 13 months", applicable to items furnished on or after January 1, 1991.

[330] P.L. 101-508, §4152(c)(1)(A), struck out "such month" and substituted "of the first 3 months of such period", applicable to items furnished on or after January 1, 1991.

[331] P.L. 101-508, §4152(c)(1)(B), inserted ", and for each of the remaining months of such period is 7.5 percent of such purchase price", applicable to items furnished on or after January 1, 1991.

[332] P.L. 101-508, §4152(c)(2)(D), added this clause, applicable to items furnished on or after January 1, 1991.

(I) the supplier shall transfer title to the item to the individual patient on the first day that begins after the 13th continuous month during which payment is made for the rental of the item under clause (i),

(II) after the supplier transfers title to the item under subclause (I), maintenance and servicing payments shall be made in accordance with clause (v);[333]

(iv) in the case of an item for which a purchase agreement has not been entered into under clause (ii) or clause (iii), during the first 6-month period of medical need that follows the period of medical need during which payment is made under clause (i),[334] no payment shall be made for rental or maintenance and servicing of the item;[335]

(v) in the case of an item for which a purchase agreement has not been entered into under clause (ii) or clause (iii),[336] during the first month of each succeeding 6-month period of medical need, a maintenance and servicing payment may be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the particular type of durable medical equipment) and the amount recognized for each such 6-month period is the lower of (I) a reasonable and necessary maintenance and servicing fee or fees established by the Secretary, or (II) 10 percent of the total of the purchase price recognized under paragraph (8) with respect to the item; and[337]

(vi) in the case of an item for which a purchase agreement has been entered into under clause (ii) or clause (iii), maintenance and servicing payments may be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the particular type of durable medical equipment), and such payments shall be in an amount established by the Secretary on the basis of reasonable charges in the locality for maintenance and servicing.[338]

The Secretary shall determine the meaning of the term "continuous" in subparagraph (A).

(B) RANGE FOR RENTAL AMOUNTS.—

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[333] P.L. 101-508, §4152(c)(2)(D), added this clause, applicable to items furnished on or after January 1, 1991.

[334] P.L. 101-508, §4152(c)(2)(B)(i), struck out "(ii) during the succeeding 6-month period of medical need," from the former clause (ii), and substituted "(iv) in the case of an item for which a purchase agreement has not been entered into under clause (ii) or clause (iii), during the first 6-month period of medical need that follows the period of medical need during which payment is made under clause (i),", applicable to items furnished on or after January 1, 1991.

[335] P.L. 101-508, §4152(c)(2)(B)(ii), struck out "and" at the end of the former clause (ii).

[336] P.L. 101-508, §4152(c)(2)(C)(i) redesignated the former clause (iii) as clause (v), and inserted "in the case of an item for which a purchase agreement has not been entered into under clause (ii) or clause (iii),", applicable to items furnished on or after January 1, 1991.

[337] P.L. 101-508, §4152(c)(2)(C)(ii), struck out a period and substituted "; and".

[338] P.L. 101-508, §4152(c)(2)(E), added clause (vi), applicable to items furnished on or after January 1, 1991.

(i) For 1989.—For items furnished during 1989, the payment amount recognized under subparagraph (A)(i) shall not be more than 115 percent, and shall not be less than 85 percent, of the prevailing charge established for rental of the item in[339] January 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987.

(ii) For 1990.—For items furnished during 1990, clause (i) shall apply in the same manner as it applies to items furnished during 1989.[340]

(C) Replacement of items.—

(i) Establishment of reasonable useful lifetime.—In accordance with clause (iii), the Secretary shall determine and establish a reasonable useful lifetime for items of durable medical equipment for which payment may be made under this paragraph or paragraph (3).

(ii) Payment for replacement items.—If the reasonable lifetime of such an item, as so established, has been reached during a continuous period of medical need, or the carrier determines that the item is lost or irreparably damaged, the patient may elect to have payment for an item serving as a replacement for such item made—

(I) on a monthly basis for the rental of the replacement item in accordance with subparagraph (A); or

(II) in the case of an item for which a purchase agreement has been entered into under subparagraph (A)(ii) or (A)(iii), in a lump-sum amount for the purchase of the item.

(iii) Length of reasonable useful lifetime.—The reasonable useful lifetime of an item of durable medical equipment under this subparagraph shall be equal to 5 years, except that, if the Secretary determines that, on the basis of prior experience in making payments for such an item under this title, a reasonable useful lifetime of 5 years is not appropriate with respect to a particular item, the Secretary shall establish an alternative reasonable lifetime for such item.[341]

(8) Purchase price recognized for miscellaneous devices and items.—For purposes of paragraphs (6) and (7), the amount that is recognized under this paragraph as the purchase price for a covered item is the amount described in subparagraph (C) of this paragraph, determined as follows:

(A) Computation of local purchase price.—Each carrier under section 1842 shall compute a base local purchase price for the item as follows:

(i) The carrier shall compute a base local purchase price, for each item described—

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[339] P.L. 101-239, §6112(a)(4)(B), inserted "in".

[340] P.L. 101-239, §6112(a)(4)(C), amended clause (ii) in its entirety, effective December 19, 1989. [For clause (ii) as it formerly read, see Vol. III, P.L. 101-239.]

[341] P.L. 101-508, §4152(c)(2)(F), added subparagraph (C), applicable to items furnished on or after January 1, 1991.

(I) in paragraph (6) equal to the average reasonable charge in the locality for the purchase of the item for the 12-month period ending with June 1987, or

(II) in paragraph (7) equal to the average of the purchase prices on the claims submitted on an assignment-related basis for the unused item supplied during the 6-month period ending with December 1986.

(ii) The carrier shall compute a local purchase price, with respect to the furnishing of each particular item—

(I) in 1989 and 1990[342], equal to the base local purchase price computed under clause (i) increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987,[343]

(II) in 1991, equal to the local purchase price computed under this clause for the previous year, increased by the covered item update for 1991, and decreased by the percentage by which the average of the reasonable charges for claims paid for all items described in paragraph (7) is lower than the average of the purchase prices submitted for such items during the final 9 months of 1988; or[344]

(III)[345] in[346] 1992, equal to the local purchase price computed under this clause for the previous year increased by the covered item update for the year.[347]

(B) COMPUTATION OF NATIONAL LIMITED PURCHASE PRICE.—With respect to the furnishing of a particular item in a year, the Secretary shall compute a national limited purchase price—

(i) for 1991, equal to the local purchase price computed under subparagraph (A)(ii) for the item for the year, except that such national limited purchase price may not exceed 100 percent of the weighted average of all local purchase prices for the item computed under such subparagraph for the year, and may not be less than 85 percent of the weighted average of all local purchase prices for the item computed under such subparagraph for the year; and

(ii) for each subsequent year, equal to the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year.[348]

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[342] P.L. 101-239, §6112(a)(2)(A), inserted "and 1990", effective December 19, 1989.

[343] P.L. 101-508, §4152(b)(2)(A)(i), struck out "or".

[344] P.L. 101-508, §4152(b)(2)(A)(iv), added this new subclause (II), applicable to items furnished on or after January 1, 1991.

[345] P.L. 101-508, §4152(b)(2)(A)(iii), redesignated the former subclause (II) as subclause (III), applicable to items furnished on or after January 1, 1991.

[346] P.L. 101-239, §6112(a)(2)(B), struck out "1990, 1991," and substituted "1991", effective December 19, 1989.

P.L. 101-508, §4152(b)(2)(A)(ii)(I), struck out "1991 or" applicable to items furnished on or after January 1, 1991.

[347] P.L. 101-508, §4152(b)(2)(A)(ii)(II), struck out "percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year." and substituted "covered item update for the year.", applicable to items furnished on or after January 1, 1991.

(C) PURCHASE PRICE RECOGNIZED.—For purposes of paragraphs (6) and (7)[349], the amount that is recognized under this paragraph as the purchase price for each item furnished—

(i) in 1989 or 1990, is 100 percent of the local purchase price computed under subparagraph (A)(ii)(I);

(ii) in 1991, is the sum of (I) 67[350] percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1991, and (II) 33[351] percent of the national limited[352] purchase price computed under subparagraph (B) for 1991;

(iii) in 1992, is the sum of (I) 33[353] percent of the local purchase price computed under subparagraph (A)(ii)(III)[354] for 1992, and (II) 67[355] percent of the national limited[356] purchase price computed under subparagraph (B) for 1992; and

(iv) in 1993 or a subsequent year, is the national limited[357] purchase price computed under subparagraph (B) for that year.

[(D) Stricken.[358]]

(9) MONTHLY PAYMENT AMOUNT RECOGNIZED WITH RESPECT TO OXYGEN AND OXYGEN EQUIPMENT.—For purposes of paragraph (5), the amount that is recognized under this paragraph for payment for oxygen and oxygen equipment is the monthly payment amount described in subparagraph (C) of this paragraph. Such amount shall be computed separately (i) for all items of oxygen and oxygen equipment (other than portable oxygen equipment) and (ii) for portable oxygen equipment (each such group referred to in this paragraph as an "item").

(A) COMPUTATION OF LOCAL MONTHLY PAYMENT RATE.—Each carrier under this section shall compute a base local payment rate for each item as follows:

(i) The carrier shall compute a base local average monthly payment rate per beneficiary as an amount equal to (I) the total reasonable charges for the item during the 12-month period ending with December 1986, divided by (II) the total number of months for all beneficiaries receiving the item in the area during the 12-month period for which the carrier made payment for the item under this title.

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[348] P.L. 101-508, §4152(b)(2)(B), amended subparagraph (B) in its entirety, applicable to items furnished on or after January 1, 1991. [For subparagraph (B) as it formerly read, see Vol. III, P.L. 101-508.]

[349] P.L. 101-508, §4152(b)(2)(C)(ii), struck out "and subject to subparagraph (D)", applicable to items furnished on or after January 1, 1991.

[350] P.L. 101-508, §4152(b)(2)(C)(iii)(I), struck out "75" and substituted "67", applicable to items furnished on or after January 1, 1991.

[351] P.L. 101-508, §4152(b)(2)(C)(iii)(II), struck out "25" and substituted "33", applicable to items furnished on or after January 1, 1991.

[352] P.L. 101-508, §4152(b)(2)(C)(i), struck out "regional" and substituted "national limited", applicable to items furnished on or after January 1, 1991.

[353] P.L. 101-508, §4152(b)(2)(C)(iv)(I), struck out "50" and substituted "33", applicable to items furnished on or after January 1, 1991.

[354] P.L. 101-508, §4152(b)(2)(C)(iv)(I), struck out "(A)(ii)(II)" and substituted "(A)(ii)(III)", applicable to items furnished on or after January 1, 1991.

[355] P.L. 101-508, §4152(b)(2)(C)(iv)(II), struck out "50" and substituted "67", applicable to items furnished on or after January 1, 1991.

[356] P.L. 101-508, §4152(b)(2)(C)(i), struck out "regional" and substituted "national limited", applicable to items furnished on or after January 1, 1991.

[357] P.L. 101-508, §4152(b)(2)(C)(i), struck out "regional" and substituted "national limited", applicable to items furnished on or after January 1, 1991.

[358] P.L. 101-508, §4152(b)(2)(D), struck out subparagraph (D), applicable to items furnished on or after January 1, 1991. [For subparagraph (D) as it formerly read, see Vol. III, P.L. 101-508.]

(ii) The carrier shall compute a local average monthly payment rate for the item applicable—

(I) to 1989 and 1990[359], equal to 95 percent of the base local average monthly payment rate computed under clause (i) for the item increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987, or

(II) to 1991[360] and 1992, equal to the local average monthly payment rate computed under this clause for the item for the previous year increased by the covered item increase for the year.[361]

(B) COMPUTATION OF NATIONAL LIMITED MONTHLY PAYMENT RATE.—With respect to the furnishing of an item in a year, the Secretary shall compute a national limited monthly payment rate equal to—

(i) for 1991, the local monthly payment rate computed under subparagraph (A)(ii)(II) for the item for the year, except that such national limited monthly payment rate may not exceed 100 percent of the weighted average of all local monthly payment rates computed for the item under such subparagraph for the year, and may not be less than 85 percent of the weighted average of all local monthly payment rates computed for the item under such subparagraph for the year; and

(ii) for each subsequent year, equal to the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year.[362]

(C) MONTHLY PAYMENT AMOUNT RECOGNIZED.—For purposes of paragraph (5), the amount that is recognized under this paragraph as the base monthly payment amount for each item furnished—

(i) in 1989 and in 1990, is 100 percent of the local average monthly payment rate computed under subparagraph (A)(ii) for the item;

(ii) in 1991, is the sum of (I) 67[363] percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1991, and (II) 33[364] percent of the national limited[365] monthly payment rate computed under subparagraph (B)(i) for the item for 1991;

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[359] P.L. 101-239, §6112(a)(3)(A), inserted "and 1990", effective December 19, 1989.

[360] P.L. 101-239, §6112(a)(3)(B), struck out "1990, 1991," and substituted "1991", effective December 19, 1989.

[361] P.L. 101-508, §4152(b)(3)(A), struck out "percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year." and substituted "covered item increase for the year.", applicable to items furnished on or after January 1, 1991.

[362] P.L. 101-508, §4152(b)(3)(B), amended subparagraph (B) in its entirety, applicable to items furnished on or after January 1, 1991. [For subparagraph (B) as it formerly read, see Vol. III, P.L. 101-508.]

[363] P.L. 101-508, §4152(b)(3)(C)(ii)(I), struck out "75" and substituted "67", applicable to items furnished on or after January 1, 1991.

[364] P.L. 101-508, §4152(b)(3)(C)(ii)(II), struck out "25" and substituted "33", applicable to items furnished on or after January 1, 1991.

(iii) in 1992, is the sum of (I) 33[366] percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1992, and (II) 67[367] percent of the national limited[368] monthly payment rate computed under subparagraph (B)(ii)[369] for the item for 1992; and

(iv) in a subsequent year, is the national limited[370] monthly payment rate computed under subparagraph (B) for the item for that year.

[(D) Stricken.[371]]

(10) Exceptions and adjustments.—

(A) Areas outside continental United States.—Exceptions to the amounts recognized under the previous provisions of this subsection shall be made to take into account the unique circumstances of covered items furnished in Alaska, Hawaii, or Puerto Rico.

(B) Adjustment for inherent reasonableness.—For covered items furnished on or after January 1, 1991, the Secretary is authorized to apply the provisions of paragraphs (8) and (9) (other than subparagraph (D)) of section 1842(b) to covered items and suppliers of such items and payments under this subsection as such provisions apply to physicians' services and physicians and a reasonable charge under section 1842(b).

(C) Transcutaneous electrical nerve stimulator (tens).—In order to permit an attending physician time to determine whether the purchase of a transcutaneous electrical nerve stimulator is medically appropriate for a particular patient, the Secretary may determine an appropriate payment amount for the initial rental of such item for a period of not more than 2 months. If such item is subsequently purchased, the payment amount with respect to such purchase is the payment amount determined under paragraph (2).

(11) Improper billing and requirement of physician order.—

(A) Improper billing for certain rental items.—Notwithstanding any other provision of this title, a supplier of a covered item for which payment is made under this subsection and which is furnished on a rental basis shall continue to supply the item without charge (other than a charge provided under this subsection for the maintenance and servicing of the item) after rental payments may no longer be made under this subsection. If a supplier knowingly and willfully violates the previous sentence, the Secretary may apply sanctions against the supplier under section 1842(j)(2) in the same manner such sanctions may apply with respect to a physician.

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[365] P.L. 101-508, §4152(b)(3)(C)(i), struck out "regional" and substituted "national limited", applicable to items furnished on or after January 1, 1991.

[366] P.L. 101-508, §4152(b)(3)(C)(iii)(I), struck out "50" and substituted "33", applicable to items furnished on or after January 1, 1991.

[367] P.L. 101-508, §4152(b)(3)(C)(iii)(II), struck out "50" and substituted "67", applicable to items furnished on or after January 1, 1991.

[368] P.L. 101-508, §4152(b)(3)(C)(i), struck out "regional" and substituted "national limited", applicable to items furnished on or after January 1, 1991.

[369] P.L. 101-508, §4152(b)(3)(C)(iii)(II), struck out "(B)(i)" and substituted "(B)(ii)", applicable to items furnished on or after January 1, 1991.

[370] P.L. 101-508, §4152(b)(3)(C)(i), struck out "regional" and substituted "national limited", applicable to items furnished on or after January 1, 1991.

[371] P.L. 101-508, §4152(b)(3)(D), struck out subparagraph (D), applicable to items furnished on or after January 1, 1991. [For subparagraph (D) as it formerly read, see Vol. III, P.L. 101-508.]

(B) REQUIREMENT OF PHYSICIAN ORDER.—The Secretary is authorized to require, for specified covered items, that payment may be made under this subsection with respect to the item only if a physician has communicated to the supplier, before delivery of the item, a written order for the item.

(12) REGIONAL CARRIERS.—The Secretary may designate, by regulation under section 1842, one carrier for one or more entire regions[372] to process all claims within the region for covered items under this section.

(13) COVERED ITEM.—In this subsection, the term "covered item" means durable medical equipment (as defined in section 1861(n)), including such equipment described in section 1861(m)(5))[373].[374]

(14) COVERED ITEM UPDATE.—In this subsection, the term "covered item update" means, with respect to a year—

(A) for 1991 and 1992, reduction of 1 percentage point; and

(B) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.[375]

(15) CARRIER DETERMINATIONS OF POTENTIALLY OVERUSED ITEMS IN ADVANCE.—

(A) DEVELOPMENT OF LIST OF ITEMS BY SECRETARY.—The Secretary shall develop and periodically update a list of items for which payment may be made under this subsection that the Secretary determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization, and shall include in such list seat-lift mechanisms, transcutaneous electrical nerve stimulators, and motorized scooters.

(B) DETERMINATIONS OF COVERAGE IN ADVANCE.—A carrier shall determine in advance whether payment for an item included on the list developed by the Secretary under subparagraph (A) may not be made because of the application of section 1862(a)(1).[376]

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[372] P.L. 101-508, §4152(b)(5), struck out "defined for purposes of paragraphs (8)(B) and (9)(B)", applicable to items furnished on or after January 1, 1991.

[373] As in original; one closing parenthesis should be stricken.

[374] P.L. 101-508, §4153(a)(2)(D)(iii), struck out a dash and subparagraphs (A)-(C), and "but does not include intraocular lenses or medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care) furnished by a home health agency under section 1861(m)(5)[*]" and substituted "durable medical equipment (as defined in section 1861(n)), including such equipment described in section 1861(m)(5))", applicable to items furnished on or after January 1, 1991. [For subparagraphs (A)-(C) as they formerly read, see Vol. III, P.L. 101-508.]

[*] P.L. 101-239, §6112(e)(2), inserted "or medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care) furnished by a home health agency under section 1861(m)(5)", applicable with respect to items furnished on or after January 1, 1990.

See Vol. II, P.L. 100-203, §4062(c), with respect to the responsibilities of the Secretary and Comptroller General.

See Vol. II, P.L. 101-508, §4153(c), with respect to a GAO study of medicare payments for prosthetic devices, orthotics, and prosthetics.

[375] P.L. 101-508, §4152(b)(4), added paragraph (14), applicable to items furnished on or after January 1, 1991.

(16) PROHIBITION AGAINST DISTRIBUTION BY SUPPLIERS OF FORMS DOCUMENTING MEDICAL NECESSITY.—

(A) IN GENERAL.—A supplier of a covered item under this subsection may not distribute to physicians or to individuals entitled to benefits under this part for commercial purposes any completed or partially completed forms or other documents required by the Secretary to be submitted to show that a covered item is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

(B) PENALTY.—Any supplier of a covered item who knowingly and willfully distributes a form or other document in violation of subparagraph (A) is subject to a civil money penalty in an amount not to exceed $1,000 for each such form or document so distributed. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1128A(a).[377]

(b) FEE SCHEDULES FOR RADIOLOGIST SERVICES.—

(1) DEVELOPMENT.—The Secretary shall develop—

(A) a relative value scale to serve as the basis for the payment for radiologist services under this part, and

(B) using such scale and appropriate conversion factors and subject to subsection (c)(1)(A)[378], fee schedules (on a regional, statewide, locality,[379] or carrier service area basis) for payment for radiologist services under this part, to be implemented for such services furnished during 1989.

(2) CONSULTATION.—In carrying out paragraph (1), the Secretary shall regularly consult closely with the Physician Payment Review Commission, the American College of Radiology, and other organizations representing physicians or suppliers who furnish radiologist services and shall share with them the data and data analysis being used to make the determinations under paragraph (1), including data on variations in current medicare payments by geographic area, and by service and physician specialty.

(3) CONSIDERATIONS.—In developing the relative value scale and fee schedules under paragraph (1), the Secretary—

(A) shall take into consideration variations in the cost of furnishing such services among geographic areas and among different sites where services are furnished, and

(B) may also take into consideration such other factors respecting the manner in which physicians in different specialties furnish such services as may be appropriate to assure that payment amounts are equitable and designed to promote effective and efficient provision of radiologist services by physicians in the different specialties.

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[376] P.L. 101-508, §4152(e), added paragraph (15), applicable to items furnished on or after January 1, 1991.

[377] P.L. 101-508, §4152(f)(1), added paragraph (16), applicable to forms and documents distributed on or after January 1, 1991.

[378] P.L. 101-234, §201(a)(1), struck out "and subject to subsection (e)(1)(A)", effective January 1, 1990.

P.L. 101-508, §4163(b)(1), inserted "and subject to subsection (c)(1)(A)", applicable to screening mammography performed on or after January 1, 1991.

[379] P.L. 101-508, §4102(f), inserted "locality,", effective as if included in the enactment of P.L. 100-203.

(4) SAVINGS.—

(A) BUDGET NEUTRAL FEE SCHEDULES.—The Secretary shall develop preliminary fee schedules for 1989, which are designed to result in the same amount of aggregate payments (net of any coinsurance and deductibles under sections 1833(a)(1)(J)[380] and 1833(b)) for radiologist services furnished in 1989 as would have been made if this subsection had not been enacted.

(B) INITIAL SAVINGS.—The fee schedules established for payment purposes under this subsection for services furnished in 1989 shall be 97 percent of the amounts permitted under these preliminary fee schedules developed under subparagraph (A).

(C) 1990 FEE SCHEDULES.—For radiologist services (other than portable X-ray services) furnished under this part during 1990, after March 31 of such year, the conversion factors used under this subsection shall be 96 percent of the conversion factors that applied under this subsection as of December 31, 1989.[381]

(D) 1991 FEE SCHEDULES.—For radiologist services (other than portable X-ray services) furnished under this part during 1991, the conversion factors used in a locality under this subsection shall be determined as follows:

(i) NATIONAL WEIGHTED AVERAGE CONVERSION FACTOR.—The Secretary shall estimate the national weighted average of the conversion factors used under this subsection for services furnished during 1990 beginning on April 1, using the best available data.

(ii) REDUCED NATIONAL WEIGHTED AVERAGE.—The national weighted average estimated under clause (i) shall be reduced by 13 percent.

(iii) COMPUTATION OF 1990 LOCALITY INDEX RELATIVE TO NATIONAL AVERAGE.—The Secretary shall establish an index which reflects, for each locality, the ratio of the conversion factor used in the locality under this subsection to the national weighted average estimated under clause (i).

(iv) LOCAL ADJUSTMENT.—Subject to clause (vii), the conversion factor to be applied to the professional or technical component of a service in a locality is the sum of 1/2 of the locally-adjusted amount determined under clause (v) and 1/2 of the GPCI-adjusted amount determined under clauses[382] (vi).

(v) LOCALLY-ADJUSTED AMOUNT.—For purposes of clause (iv), the locally adjusted amount determined under this clause is the product of (I) the national weighted average conversion factor computed under clause (ii), and (II) the index value established under clause (iii) for the locality.

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[380] P.L. 101-234, §301(b)(1), struck out "insurance and deductibles under section 1835(a)(1)(I)" and substituted "coinsurance and deductibles under sections 1833(a)(1)(J)", effective as if included in the enactment of P.L. 100-203.

P.L. 101-234, §301(c)(1), made the same amendment.

[381] P.L. 101-239, §6105(a)(2), added this subparagraph, effective December 19, 1989.

[382] As in original; possibly should be "clause".

(vi) GPCI-adjusted amount.—For purposes of clause (iv), the GPCI-adjusted amount determined under this clause is the sum of—

(I) the product of (a) the portion of the reduced national weighted average conversion factor computed under clause (ii) which is attributable to physician work and (b) the geographic work index value for the locality (specified in Addendum C to the Model Fee Schedule for Physician Services (published on September 4, 1990, 55 Federal Register pp. 36238-36243)); and

(II) the product of (a) the remaining portion of the reduced national weighted average conversion factor computed under clause (ii), and (b) the geographic practice cost index value specified in section 1842(b)(14)(C)(iv) for the locality.

In applying this clause with respect to the professional component of a service, 80 percent of the conversion factor shall be considered to be attributable to physician work and with respect to the technical component of the service, 0 percent shall be considered to be attributable to physician work.

(vii) Limits on conversion factor.—The conversion factor to be applied to a locality under this subparagraph to the professional or technical component of a service shall not be more than 9.5 percent below the conversion factor applied in the locality under subparagraph (C) to such component, but in no case shall the conversion factor be less than 60 percent of the national weighted average of the conversion factors (computed under clause (i)).[383]

(E) In the case of the technical components of magnetic resonance imaging (MRI) services and computer assisted tomography (CAT) services furnished after December 31, 1990, the amount otherwise payable shall be reduced by 10 percent.[384]

(E)[385] Subsequent updating.—For radiologist services furnished in subsequent years, the fee schedules shall be the schedules for the previous year updated by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year.

(F)[386] Nonparticipating physicians and suppliers.—Each fee schedule so established shall provide that the payment rate recognized for nonparticipating physicians and suppliers is equal to the appropriate percent (as defined in section 1842(b)(4)(A)(iv)) of the payment rate recognized for participating physicians and suppliers.

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[383] P.L. 101-508, §4102(a)(2), inserted this subparagraph (D), applicable to services furnished on or after January 1, 1991.

[384] P.L. 101-508, §4102(d), inserted this subparagraph (E), applicable to services furnished on or after January 1, 1991.

[385] P.L. 101-239, §6105(a)(1), redesignated the former subparagraph (C) as subparagraph (D).
P.L. 101-508, §4102(a)(1), redesignated that subparagraph (D) as subparagraph (E).

[386] P.L. 101-239, §6105(a)(1), redesignated the former subparagraph (D) as subparagraph (E).
P.L. 101-508, §4102(a)(1), redesignated that subparagraph (E) as subparagraph (F).

(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS AND SUPPLIERS.—

(A) IN GENERAL.—In the case of radiologist services furnished after January 1, 1989, for which payment is made under a fee schedule under this subsection, if a nonparticipating physician or supplier furnishes the service to an individual entitled to benefits under this part, the physician or supplier may not charge the individual more than the limiting charge (as defined in subparagraph (B)).

(B) LIMITING CHARGE DEFINED.—In subparagraph (A), the term "limiting charge" means, with respect to a service furnished—

(i) in 1989, 125 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1),

(ii) in 1990, 120 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1), and

(iii) after 1990, 115 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1).

(C) ENFORCEMENT.—If a physician or supplier knowingly and willfully bills in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2) in the same manner as such sanctions may apply to a physician.

(6) RADIOLOGIST SERVICES DEFINED.—For the purposes of this subsection and section 1833(a)(1)(J), the term "radiologist services" only includes radiology services performed by, or under the direction or supervision of, a physician—

(A) who is certified, or eligible to be certified, by the American Board of Radiology, or

(B) for whom radiology services account for at least 50 percent of the total amount of charges made under this part.[387]

(c) PAYMENTS AND STANDARDS FOR SCREENING MAMMOGRAPHY.—

(1) IN GENERAL.—Notwithstanding any other provision of this part, with respect to expenses incurred for screening mammography (as defined in section 1861(jj))—

(A) payment may be made only for screening mammography conducted consistent with the frequency permitted under paragraph (2);

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[387] P.L. 100-203, §4049(a)(2), added subsection (b), applicable to services performed on or after April 1, 1989*.

*P.L. 101-239, §6102(e)(6)(B), struck out ", and until such time as the Secretary of Health and Human Services implements physician fee schedules based on the relative value scale developed under section 1845(e) of the Social Security Act", effective December 19, 1989.

P.L. 101-508, §4118(h)(2), struck out "January 1, 1989" and substituted "April 1, 1989".

See Vol. II, P.L. 100-203, §4049(b)(1), with respect to the Secretary's responsibilities regarding fee schedules for radiologist services.

See Vol. II, P.L. 101-239, §6105(b), with respect to the special rule for nuclear medicine physicians; and §6105(c), with respect to interventional radiologists.

See Vol. II, P.L. 101-508, §4102(e), with respect to radiology services during 1991.

(B) payment may be made only if the screening mammography meets the quality standards established under paragraph (3); and

(C) the amount of the payment under this part shall, subject to the deductible established under section 1833(b), be equal to 80 percent of the least of—

(i) the actual charge for the screening,

(ii) the fee schedule established under subsection (b) or the fee schedule established under section 1848, whichever is applicable, with respect to both the professional and technical components of the screening mammography, or

(iii) the limit established under paragraph (4) for the screening mammography.

(2) FREQUENCY COVERED.—

(A) IN GENERAL.—Subject to revision by the Secretary under subparagraph (B)—

(i) No payment may be made under this part for screening mammography performed on a woman under 35 years of age.

(ii) Payment may be made under this part for only 1 screening mammography performed on a woman over 34 years of age, but under 40 years of age.

(iii) In the case of a woman over 39 years of age, but under 50 years of age, who—

(I) is at a high risk of developing breast cancer (as determined pursuant to factors identified by the Secretary), payment may not be made under this part for a screening mammography performed within the 11 months following the month in which a previous screening mammography was performed, or

(II) is not at a high risk of developing breast cancer, payment may not be made under this part for a screening mammography performed within the 23 months following the month in which a previous screening mammography was performed.

(iv) In the case of a woman over 49 years of age, but under 65 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.

(v) In the case of a woman over 64 years of age, payment may not be made for screening mammography performed within 23 months following the month in which a previous screening mammography was performed.

(B) REVISION OF FREQUENCY.—

(i) REVIEW.—The Secretary, in consultation with the Director of the National Cancer Institute, shall review periodically the appropriate frequency for performing screening mammography, based on age and such other factors as the Secretary believes to be pertinent.

(ii) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which screening mammography may be paid for under this subsection, but no such revision shall apply to screening mammography performed before January 1, 1992.

(3) QUALITY STANDARDS.—The Secretary shall establish standards to assure the safety and accuracy of screening mammography performed under this part. Such standards shall include the requirements that—

(A) the equipment used to perform the mammography must be specifically designed for mammography and must meet radiologic standards established by the Secretary for mammography;

(B) the mammography must be performed by an individual who—

(i) is licensed by a State to perform radiological procedures, or

(ii) is certified as qualified to perform radiological procedures by such an appropriate organization as the Secretary specifies in regulations;

(C) the results of the mammography must be interpreted by a physician—

(i) who is certified as qualified to interpret radiological procedures by such an appropriate board as the Secretary specifies in regulations, or

(ii) who is certified as qualified to interpret screening mammography procedures by such a program as the Secretary recognizes in regulation as assuring the qualifications of the individual with respect to such interpretation; and

(D) with respect to the first screening mammography performed on a woman for which payment is made under this part, there are satisfactory assurances that the results of the mammography will be placed in permanent medical records maintained with respect to the woman.

(4) LIMIT.—

(A) $55, INDEXED.—Except as provided by the Secretary under subparagraph (B), the limit established under this paragraph—

(i) for screening mammography performed in 1991, is $55, and

(ii) for screening mammography performed in a subsequent year is the limit established under this paragraph for the preceding year increased by the percentage increase in the MEI for that subsequent year.

(B) REDUCTION OF LIMIT.—The Secretary shall review from time to time the appropriateness of the amount of the limit established under this paragraph. The Secretary may, with respect to screening mammography performed in a year after 1992, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that screening mammography of an appropriate quality is readily and conveniently available during the year.

(C) APPLICATION OF LIMIT IN HOSPITAL OUTPATIENT SETTING.—The Secretary shall provide for an appropriate allocation of the limit established under this paragraph between professional and technical components in the case of hospital outpatient screening mammography (and comparable situations) where there is a claim for professional services separate from the claim for the radiologic procedure.

(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

(A) IN GENERAL.—In the case of mammography screening performed on or after January 1, 1991, for which payment is made under this subsection, if a nonparticipating physician or supplier provides the screening to an individual entitled to benefits under this part, the physician or supplier may not charge the individual more than the limiting charge (as defined in subparagraph (B), or if less, as defined in subsection (b)(5)(B) or as defined in section 1848(g)(2)).

(B) LIMITING CHARGE DEFINED.—In subparagraph (A), the term "limiting charge" means, with respect to screening mammography performed—

(i) in 1991, 125 percent of the limit established under paragraph (4),

(ii) in 1992, 120 percent of the limit established under paragraph (4), or

(iii) after 1992, 115 percent of the limit established under paragraph (4).

(C) ENFORCEMENT.—If a physician or supplier knowing[388] and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).[389]

[(d) Repealed.[390]]

[(e) Repealed.[391]]

(f) REDUCTION IN PAYMENTS FOR PHYSICIAN PATHOLOGY SERVICES DURING FISCAL YEAR 1991.—

(1) IN GENERAL.—For physician pathology services furnished under this part during 1991, the prevailing charges used in a locality under this part shall be 7 percent below the prevailing charges used in the locality under this part in 1990 after March 31.

(2) LIMITATION.—The prevailing charge for the technical and professional components of an[392] physician pathology service

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[388] As in original; possibly should be "knowingly".

[389] P.L. 100-360, §202(b)(4), added subsection (c), applicable to items dispensed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed that subsection (c), effective January 1, 1990. [For subsection (c) as it formerly read, see Vol. III, P.L. 101-234.].

P.L. 101-508, §4163(b)(2), inserted this subsection (c), applicable to screening mammography performed on or after January 1, 1991.

See Vol. II, P.L. 101-234, §203(b), with respect to the adjustment of contracts with prepaid health plans.

[390] P.L. 100-360, §203(c)(1)(F), added subsection (d), applicable to items and services furnished on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed subsection (d), effective January 1, 1990. [For subsection (d) as it formerly read, see Vol. III, P.L. 101-234.]

[391] P.L. 100-360, §204(b)(2), added subsection (e), applicable to screening mammography performed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed subsection (e), effective January 1, 1990. [For subsection (e) as it formerly read, see Vol. III, P.L. 101-234.]

[392] As in original; possibly should be "a".

furnished by a physician through an independent laboratory shall not be reduced pursuant to paragraph (1) to the extent that such reduction would reduce such prevailing charge below 115 percent of the prevailing charge for the professional component of such service when furnished by a hospital-based physician in the same locality. For purposes of the preceding sentence, an independent laboratory is a laboratory that is independent of a hospital and separate from the attending or consulting physicians' office.[393]

(g) PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IN GENERAL.—The amount of payment for outpatient rural primary care hospital services provided during a year before 1993 in a rural primary care hospital under this part shall be determined by one of the 2 following methods, as elected by the rural primary care hospital:

(A) COST-BASED FACILITY FEE PLUS PROFESSIONAL CHARGES.—

(i) FACILITY FEE.—With respect to facility services, not including any services for which payment may be made under clause (ii), there shall be paid amounts equal to the amounts described in section 1833(a)(2)(B) (describing amounts paid for hospital outpatient services).

(ii) REASONABLE CHARGES FOR PROFESSIONAL SERVICES.—In electing treatment under this subparagraph, payment for professional medical services otherwise included within outpatient rural primary care hospital services shall be made under such other provisions of this part as would apply to payment for such services if they were not included in outpatient rural primary care hospital services.

(B) ALL-INCLUSIVE RATE.—With respect to both facility services and professional medical services, there shall be paid amounts equal to the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, less the amount the hospital may charge as described in clause (i) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A) and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion) exceed 80 percent of such costs.

(2) DEVELOPMENT AND IMPLEMENTATION OF ALL INCLUSIVE, PROSPECTIVE PAYMENT SYSTEM.—Not later than January 1, 1993, the Secretary shall develop and implement a prospective payment system for determining payments under this part for outpatient rural primary care hospital services using a methodology that includes all costs in providing all such services (including related professional medical services) and that deter-

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[393] P.L. 101-239, §6102(f)(1), added subsection (f), applicable to services furnished on or after January 1, 1991.

P.L. 101-508, §4104(a), amended subsection (f) in its entirety, applicable to services furnished on or after January 1, 1991. [For subsection (f) as it formerly read, see Vol. III, P.L. 101-508.]

mines the payment amount for such services on a prospective basis.[394]

(h) PAYMENT FOR PROSTHETIC DEVICES AND ORTHOTICS AND PROSTHETICS.—

(1) GENERAL RULE FOR PAYMENT.—

(A) IN GENERAL.—Payment under this subsection for prosthetic devices and orthotics and prosthetics shall be made in a lump-sum amount for the purchase of the item in an amount equal to 80 percent of the payment basis described in subparagraph (B).

(B) PAYMENT BASIS.—Except as provided in subparagraph (C), the payment basis described in this subparagraph is the lesser of—

(i) the actual charge for the item; or

(ii) the amount recognized under paragraph (2) as the purchase price for the item.

(C) EXCEPTION FOR CERTAIN PUBLIC HOME HEALTH AGENCIES.—Subparagraph (B)(i) shall not apply to an item furnished by a public home health agency (or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low income) free of charge or at nominal charges to the public.

(D) EXCLUSIVE PAYMENT RULE.—This subsection shall constitute the exclusive provision of this title for payment for prosthetic devices, orthotics, and prosthetics under this part or under part A to a home health agency.

(2) PURCHASE PRICE RECOGNIZED.—For purposes of paragraph (1), the amount that is recognized under this paragraph as the purchase price for prosthetic devices, orthotics, and prosthetics is the amount described in subparagraph (C) of this paragraph, determined as follows:

(A) COMPUTATION OF LOCAL PURCHASE PRICE.—Each carrier under section 1842 shall compute a base local purchase price for the item as follows:

(i) The carrier shall compute a base local purchase price for each item equal to the average reasonable charge in the locality for the purchase of the item for the 12-month period ending with June 1987.

(ii) The carrier shall compute a local purchase price, with respect to the furnishing of each particular item—

(I) in 1989 and 1990, equal to the base local purchase price computed under clause (i) increased by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 6-month period ending with December 1987, or

(II) in 1991, 1992 or 1993, equal to the local purchase price computed under this clause for the previous year increased by the applicable percentage increase for the year.

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[394] P.L. 101-239, §6116(b)(2), added subsection (g), effective December 19, 1989.

(B) COMPUTATION OF REGIONAL PURCHASE PRICE.—With respect to the furnishing of a particular item in each region (as defined by the Secretary), the Secretary shall compute a regional purchase price—

(i) for 1992, equal to the average (weighted by relative volume of all claims among carriers) of the local purchase prices for the carriers in the region computed under subparagraph (A)(ii)(II) for the year, and

(ii) for each subsequent year, equal to the regional purchase price computed under this subparagraph for the previous year increased by the applicable percentage increase for the year.

(C) PURCHASE PRICE RECOGNIZED.—For purposes of paragraph (1) and subject to subparagraph (D), the amount that is recognized under this paragraph as the purchase price for each item furnished—

(i) in 1989, 1990, or 1991, is 100 percent of the local purchase price computed under subparagraph (A)(ii);

(ii) in 1992, is the sum of (I) 75 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1992, and (II) 25 percent of the regional purchase price computed under subparagraph (B) for 1992;

(iii) in 1993, is the sum of (I) 50 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1993, and (II) 50 percent of the regional purchase price computed under subparagraph (B) for 1993; and

(iv) in 1994 or a subsequent year, is the regional purchase price computed under subparagraph (B) for that year.

(D) RANGE ON AMOUNT RECOGNIZED.—The amount that is recognized under subparagraph (C) as the purchase price for an item furnished—

(i) in 1992, may not exceed 125 percent, and may not be lower than 85 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year; and

(ii) in a subsequent year, may not exceed 120 percent, and may not be lower than 90 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year.

(3) APPLICABILITY OF CERTAIN PROVISIONS RELATING TO DURABLE MEDICAL EQUIPMENT.—Paragraph (12) and subparagraphs (A) and (B) of paragraph (10) and paragraph (11) of subsection (a) shall apply to prosthetic devices, orthotics, and prosthetics in the same manner as such provisions apply to covered items under such subsection.

(4) DEFINITIONS.—In this subsection—

(A) the term "applicable percentage increase" means—

(i) for 1991, 0 percent, and

(ii) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

(B) the term "prosthetic devices" has the meaning given such term in section 1861(s)(8), except that such term does not include parenteral and enteral nutrition nutrients, supplies, and equipment; and

(C) the term "orthotics and prosthetics" has the meaning given such term in section 1861(s)(9), but does not include intraocular lenses or medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care) furnished by a home health agency under section 1861(m)(5).[395]

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. [42 U.S.C. 1395n] (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year; and

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needs or needed skilled nursing care on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(B) in the case of medical and other health services, except services described in subparagraphs (B), (C), and (D) of section 1861(s)(2), such services are or were medically required;

(C) in the case of outpatient physical therapy services or outpatient occupational therapy services, (i) such services are or were required because the individual needed physical therapy services or occupational therapy services, respectively, (ii) a plan for furnishing such services has been established by a physician or by the qualified physical therapist or qualified occupational therapist, respectively, providing such services and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

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[395] P.L. 101-508, §4153(a)(1), added subsection (h), applicable to items furnished on or after January 1, 1991.

(D) in the case of outpatient speech pathology services, (i) such services are or were required because the individual needed speech pathology services, (ii) a plan for furnishing such services has been established by a physician or by the speech pathologist providing such services and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(E) in the case of comprehensive outpatient rehabilitation facility services, (i) such services are or were required because the individual needed skilled rehabilitation services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician; and[396]

(F) in the case of partial hospitalization services, (i) the individual would require inpatient psychiatric care in the absence of such services, (ii) an individualized, written plan for furnishing such services has been established by a physician and is reviewed periodically by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician.[397]

[(G) Repealed.[398]]

[(H) Repealed.[399]]

For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of section 1861(g)), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of section 1861(g)), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services.

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[396] P.L. 100-360, §203(d)(1)(A), struck out "and", effective January 1, 1990.

P.L. 101-234, §201(a)(1), repealed P.L. 100-360, §203(d)(1)(A), effective January 1, 1990.

[397] P.L. 100-360, §203(d)(1)(B), struck out the period and substituted "; and", effective January 1, 1990.

P.L. 100-360, §205(d)(1), struck out "and", effective January 1, 1990.

P.L. 101-234, §201(a)(1), repealed P.L. 100-360, §203(d)(1)(B) and §205(d)(1), effective January 1, 1990.

[398] P.L. 100-360, §203(d)(1)(C), added subparagraph (G), applicable to items and services furnished on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed subparagraph (G), effective January 1, 1990. [For subparagraph (G) as it formerly read, see Vol. III, P.L. 101-234.]

[399] P.L. 100-360, §205(d)(3), added subparagraph (H), applicable to items and services furnished on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed subparagraph (H), effective January 1, 1990. [For subparagraph (H) as it formerly read, see Vol. III, P.L. 101-234.]

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of paragraph (2)(A), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences of the individual from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.

(b)(1) Payment may also be made to any hospital for services described in section 1861(s) furnished as an outpatient service by a hospital or by others under arrangements made by it to an individual entitled to benefits under this part even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has made an election pursuant to section 1814(d)(1)(C) with respect to the calendar year in which such emergency services are provided. Such payments shall be made only in the amounts provided under section 1833(a)(2) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1866(a).

(2) Payment may also be made on the basis of an itemized bill to an individual for services described in paragraph (1) of this subsection if (A) payment cannot be made under such paragraph (1) solely because the hospital does not elect, in accordance with section 1814(d)(1)(C), to claim such payments and (B) such individual files application (sub-

mitted within such time and in such form and manner, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amounts payable under this paragraph shall, subject to the provisions of section 1833, be equal to 80 percent of the hospital's reasonable charges for such services.

(c) Notwithstanding the provisions of this section and sections 1832, 1833, and 1866(a)(1)(A), a hospital or a rural primary care hospital[400] may, subject to such limitations as may be prescribed by regulations, collect from an individual the customary charges for services specified in section 1861(s) and furnished to him by such hospital as an outpatient, but only if such charges for such services do not exceed the applicable supplementary medical insurance deductible, and such customary charges shall be regarded as expenses incurred by such individual with respect to which benefits are payable in accordance with section 1833(a)(1). Payments under this title to hospitals which have elected to make collections from individuals in accordance with the preceding sentence shall be adjusted periodically to place the hospital in the same position it would have been had it instead been reimbursed in accordance with section 1833(a)(2) (or, in the case of a rural primary care hospital, in accordance with section 1833(a)(6))[401].[402]

(d) Subject to section 1880, no payment may be made under this part to any Federal provider of services or other Federal agency, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services or other person for any item or service which such provider or person is obligated by a law of, or a contract with, the United States to render at public expense.

(e) For purposes of services (1) which are inpatient hospital services by reason of paragraph (7) of section 1861(b) or for which entitlement exists by reason of clause (II) of section 1832(a)(2)(B)(i), and (2) for which the reasonable cost thereof is determined under section 1861(v)(1)(D) (or would be if section 1886 did not apply), payment under this part shall be made to such fund as may be designated by the organized medical staff of the hospital in which such services were furnished or, if such services were furnished in such hospital by the faculty of a medical school, to such fund as may be designated by such faculty, but only if—

(A) such hospital has an agreement with the Secretary under section 1866, and

(B) the Secretary has received written assurances that (i) such payment will be used by such fund solely for the improvement of care to patients in such hospital or for educational or charitable purposes and (ii) the individuals who were furnished such services or any other persons will not be charged for such services (or if charged provision will be made for return of any moneys incorrectly collected).

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[400] P.L. 101-508, §4008(m)(2)(D)(i), inserted "or a rural primary care hospital", effective November 5, 1990.

[401] P.L. 101-508, §4008(m)(2)(D)(ii), inserted "(or, in the case of a rural primary care hospital, in accordance with section 1833(a)(6))", effective November 5, 1990.

[402] P.L. 101-239, §6003(g)(3)(D)(viii), added "A rural primary care hospital shall be considered a hospital for purposes of this subsection.", effective December 19, 1989.

P.L. 101-508, §4008(m)(2)(D)(iii), struck out that sentence, effective November 5, 1990.

ELIGIBLE INDIVIDUALS

SEC. 1836. [42 U.S.C. 1395o] Every individual who—

(1) is entitled to hospital insurance benefits under part A, or

(2) has attained age 65 and is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part,

is eligible to enroll in the insurance program established by this part.

ENROLLMENT PERIODS

SEC. 1837. [42 U.S.C. 1395p] (a) An individual may enroll in the insurance program established by this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this section.

[(b) Repealed.[403]]

(c) In the case of individuals who first satisfy paragraph (1) or (2) of section 1836 before March 1, 1966, the initial general enrollment period shall begin on the first day of the second month[404] which begins after the date of enactment of this title[405] and shall end on May 31, 1966. For purposes of this subsection and subsection (d), an individual who has attained age 65 and who satisfies paragraph (1) of section 1836 but not paragraph (2) of such section shall be treated as satisfying such paragraph (1) on the first day on which he is (or on filing application would have been) entitled to hospital insurance benefits under part A.

(d) In the case of an individual who first satisfies paragraph (1) or (2) of section 1836 on or after March 1, 1966, his initial enrollment period shall begin on the first day of the third month before the month in which he first satisfies such paragraphs and shall end seven months later. Where the Secretary finds that an individual who has attained age 65 failed to enroll under this part during his initial enrollment period (based on a determination by the Secretary of the month in which such individual attained age 65), because such individual (relying on documentary evidence) was mistaken as to his correct date of birth, the Secretary shall establish for such individual an initial enrollment period based on his attaining age 65 at the time shown in such documentary evidence (with a coverage period determined under section 1838 as though he had attained such age at that time).

(e) There shall be a general enrollment period during the period beginning on January 1 and ending on March 31 of each year.

(f) Any individual—

(1) who is eligible under section 1836 to enroll in the medical insurance program by reason of entitlement to hospital insurance benefits as described in paragraph (1) of such section, and

(2) whose initial enrollment period under subsection (d) begins after March 31, 1973, and

(3) who is residing in the United States, exclusive of Puerto Rico,

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[403] P.L. 96-499, §945(a); 94 Stat. 2642.

[404] September 1, 1965; July 30, 1965, is the date of enactment of P.L. 89-97 (79 Stat. 286) which added title XVIII to the Act.

[405] September 1, 1965; July 30, 1965, is the date of enactment of P.L. 89-97 (79 Stat. 286) which added title XVIII to the Act.

shall be deemed to have enrolled in the medical insurance program established by this part.

(g) All of the provisions of this section shall apply to individuals satisfying subsection (f), except that—

(1) in the case of an individual who satisfies subsection (f) by reason of entitlement to disability insurance benefits described in section 226(b), his initial enrollment period shall begin on the first day of the later of (A) April 1973 or (B) the third month before the 25th month of such entitlement, and shall reoccur with each continuous period of eligibility (as defined in section 1839(d)) and upon attainment of age 65;

(2)(A) in the case of an individual who is entitled to monthly benefits under section 202 or 223 on the first day of his initial enrollment period or becomes entitled to monthly benefits under section 202 during the first 3 months of such period, his enrollment shall be deemed to have occurred in the third month of his initial enrollment period, and

(B) in the case of an individual who is not entitled to benefits under section 202 on the first day of his initial enrollment period and does not become so entitled during the first 3 months of such period, his enrollment shall be deemed to have occurred in the month in which he files the application establishing his entitlement to hospital insurance benefits provided such filing occurs during the last 4 months of his initial enrollment period; and

(3) in the case of an individual who would otherwise satisfy subsection (f) but does not establish his entitlement to hospital insurance benefits until after the last day of his initial enrollment period (as defined in subsection (d) of this section), his enrollment shall be deemed to have occurred on the first day of the earlier of the then current or immediately succeeding general enrollment period (as defined in subsection (e) of this section).

(h) In any case where the Secretary finds that an individual's enrollment or nonenrollment in the insurance program established by this part or part A pursuant to section 1818 is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Federal Government, or its instrumentalities, the Secretary may take such action (including the designation for such individual of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums) as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

(i)(1) In the case of an individual who—

(A)[406] at the time the individual first satisfies paragraph (1) or (2) of section 1836, is enrolled in a group health plan described in section 1862(b)(1)(A)(v)[407] by reason of the individual's (or the individual's spouse's) current employment, and

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[406] P.L. 101-239, §6202(c)(1)(A)(i), struck out subparagraph (A), applicable to enrollments occurring after, and premiums for months after, the calendar quarter beginning April 1, 1990. [For subparagraph (A) as it formerly read, see Vol. III, P.L. 101-239.]

P.L. 101-239, §6202(c)(1)(A)(ii), redesignated the former subparagraph (B) as subparagraph (A), applicable to enrollments occurring after, and premiums for months after, the calendar quarter beginning April 1, 1990.

[407] P.L. 101-239, §6202(b)(4)(C), struck out "1862(b)(3)(A)(iv)" and substituted "1862(b)(1)(A)(v)", applicable to items and services furnished after December 19, 1989.

(B)[408] has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period,

there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence[409] who has not attained the age of 65, at the time the individual first satisfies paragraph (1) of section 1836, is enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(1)(B)(iv)[410]), and has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (3)(B).

(2) In the case of an individual who—

(A)[411](i) has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or (ii) is an individual described in paragraph (1)(A)[412];

(B)[413] has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a group health plan described in section 1862(b)(1)(A)(v)[414] by reason of the individual's (or individual's spouse's) current employment; and

(C)[415] has not terminated enrollment under this section at any time at which the individual is not enrolled in such a group health plan by reason of the individual's (or individual's spouse's) current employment,

there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence[416] who has not attained the age of 65, has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or is an individual described in the second sentence of paragraph (1), has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(1)(B)(iv)[417]), and has not terminated enrollment under this section at any time at which the individual is not enrolled in such a large group health plan as an active individual, there shall be a special enrollment period described in paragraph (3)(B).

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[408] P.L. 101-239, §6202(c)(1)(A)(ii), redesignated the former subparagraph (C) as subparagraph (B), applicable to enrollments occurring after, and premiums for months after, the calendar quarter beginning April 1, 1990.

[409] P.L. 101-239, §6202(c)(1)(A)(iii), inserted "not described in the previous sentence", applicable to enrollments occurring after, and premiums for months after, the calendar quarter beginning April 1, 1990.

[410] P.L. 101-239, §6202(b)(4)(C), struck out "1862(b)(4)(B)" and substituted "1862(b)(1)(B)(iv)", applicable to items and services furnished after December 19, 1989.

[411] P.L. 101-239, §6202(c)(1)(B)(ii), struck out subparagraph (A), applicable as the amendment made by P.L. 101-239, §6202(c)(1)(A)(ii). [For subparagraph (A) as it formerly read, see Vol. III, P.L. 101-239.]

P.L. 101-239, §6202(c)(1)(B)(iii), redesignated the former subparagraph (B) as subparagraph (A), applicable as the amendment made by P.L. 101-239, §6202(c)(1)(A)(ii).

[412] P.L. 101-239, §6202(c)(1)(B)(i), struck out "(1)(B)" and substituted "(1)(A)", applicable as the amendment made by P.L. 101-239, §6202(c)(1)(A)(ii).

[413] P.L. 101-239, §6202(c)(1)(B)(iii), redesignated the former subparagraph (C) as subparagraph (B), applicable as the amendment made by P.L. 101-239, §6202(c)(1)(A)(ii).

[414] P.L. 101-239, §6202(b)(4)(C), struck out "1862(b)(3)(A)(iv)" and substituted "1862(b)(1)(A)(v)", applicable to items and services furnished after December 19, 1989.

[415] P.L. 101-239, §6202(c)(1)(B)(iii), redesignated the former subparagraph (D) as subparagraph (C), applicable as the amendment made by P.L. 101-239, §6202(c)(1)(A)(ii).

[416] P.L. 101-239, §6202(c)(1)(B)(iv), inserted "not described in the previous sentence", applicable as the amendment made by P.L. 101-239, §6202(c)(1)(A)(ii).

[417] P.L. 101-239, §6202(b)(4)(C), struck out "1862(b)(4)(B)" and substituted "1862(b)(1)(B)(iv)", applicable to items and services furnished after December 19, 1989.

(3)(A) The special enrollment period referred to in the first sentences of paragraphs (1) and (2) is the period beginning with the first day of the first month in which the individual is no longer enrolled in a group health plan described in section 1862(b)(1)(A)(v)[418] by reason of current employment and ending seven months later.

(B) The special enrollment period referred to in the second sentences of paragraphs (1) and (2) is the period beginning with the first day of the first month in which the individual is no longer enrolled as an active individual in a large group health plan (as such terms are defined in section 1862(b)(1)(B)(iv)[419]) and ending seven months later.

COVERAGE PERIOD

SEC. 1838. [42 U.S.C. 1395q] (a) The period during which an individual is entitled to benefits under the insurance program established by this part (hereinafter referred to as his "coverage period") shall begin on whichever of the following is the latest:

(1) July 1, 1966[420] or (in the case of a disabled individual who has not attained age 65) July 1, 1973; or

(2)(A) in the case of an individual who enrolls pursuant to subsection (d) of section 1837 before the month in which he first satisfies paragraph (1) or (2) of section 1836, the first day of such month, or

(B) in the case of an individual who enrolls pursuant to such subsection (d) in the month in which he first satisfies such paragraph, the first day of the month following the month in which he so enrolls, or

(C) in the case of an individual who enrolls pursuant to such subsection (d) in the month following the month in which he first satisfies such paragraph, the first day of the second month following the month in which he so enrolls, or

(D) in the case of an individual who enrolls pursuant to such subsection (d) more than one month following the month in which he satisfies such paragraph, the first day of the third month following the month in which he so enrolls, or

(E) in the case of an individual who enrolls pursuant to subsection (e) of section 1837, the July 1 following the month in which he so enrolls; or

(3)(A) in the case of an individual who is deemed to have enrolled on or before the last day of the third month of his initial enrollment period, the first day of the month in which he first meets the applicable requirements of section 1836 or July 1, 1973, whichever is later, or

(B) in the case of an individual who is deemed to have enrolled on or after the first day of the fourth month of his initial enrollment period, as prescribed under subparagraphs (B), (C), (D), and (E) of paragraph (2) of this subsection.

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[418] P.L. 101-239, §6202(b)(4)(C), struck out "1862(b)(3)(A)(iv)" and substituted "1862(b)(1)(A)(v)", applicable to items and services furnished after December 19, 1989.

[419] P.L. 101-239, §6202(b)(4)(C), struck out "1862(b)(4)(B)" and substituted "1862(b)(1)(B)(iv)", applicable to items and services furnished after December 19, 1989.

[420] As in original. No comma after "1966".

(b) An individual's coverage period shall continue until his enrollment has been terminated—

(1) by the filing of notice that the individual no longer wishes to participate in the insurance program established by this part, or

(2) for nonpayment of premiums.

The termination of a coverage period under paragraph (1) shall (except as otherwise provided in section 1843(e)) take effect at the close of the month following the month in which the notice is filed. The termination of a coverage period under paragraph (2) shall take effect on a date determined under regulations, which may be determined so as to provide a grace period in which overdue premiums may be paid and coverage continued. The grace period determined under the preceding sentence shall not exceed 90 days; except that it may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period.

Where an individual who is deemed to have enrolled for medical insurance pursuant to section 1837(f) files a notice before the first day of the month in which his coverage period begins advising that he does not wish to be so enrolled, the termination of the coverage period resulting from such deemed enrollment shall take effect with the first day of the month the coverage would have been effective. Where an individual who is deemed enrolled for medical insurance benefits pursuant to section 1837(f) files a notice requesting termination of his deemed coverage in or after the month in which such coverage becomes effective, the termination of such coverage shall take effect at the close of the month following the month in which the notice is filed.

(c) In the case of an individual satisfying paragraph (1) of section 1836 whose entitlement to hospital insurance benefits under part A is based on a disability rather than on his having attained the age of 65, his coverage period (and his enrollment under this part) shall be terminated as of the close of the last month for which he is entitled to hospital insurance benefits.

(d) No payments may be made under this part with respect to the expenses of an individual unless such expenses were incurred by such individual during a period which, with respect to him, is a coverage period.

(e) Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section 1837(i)(3)—

(1) in the first month of the special enrollment period, the coverage period shall begin on the first day of that month, or

(2) in a month after the first month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.

AMOUNTS OF PREMIUMS

SEC. 1839. [42 U.S.C. 1395r] (a)(1) The Secretary shall, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to those enrollees age 65 and older will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees[421]. In calculating the monthly actuarial rate, the Secretary shall include an appropriate amount for a contingency margin[422].

(2) The monthly premium of each individual enrolled under this part for each month after December 1983 shall, except as provided in subsections (b) and (e)[423], be the amount determined under paragraph (3).

(3) The Secretary shall, during September of 1983 and of each year thereafter, determine and promulgate the monthly premium applicable for individuals enrolled under this part for the succeeding calendar year. The monthly premium shall (except as otherwise provided in subsection (e)[424]) be equal to the smaller of—

(A) the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1) of this subsection, for that calendar year, or

(B) the monthly premium rate most recently promulgated by the Secretary under this paragraph, increased by a percentage determined as follows: The Secretary shall ascertain the primary insurance amount computed under section 215(a)(1), based upon average indexed monthly earnings of $900, that applied to individuals who became eligible for and entitled to old-age insurance benefits on November 1 of the year before the year of the promulgation. He shall increase the monthly premium rate by the same percentage by which that primary insurance amount is increased when, by reason of the law in effect at the time the promulgation is made, it is so computed to apply to those individuals for the following November 1.

Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and older as provided in paragraph (1) and the derivation of the dollar amounts specified in this paragraph.

(4) The Secretary shall also, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for disabled enrollees under age 65 which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary

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[421] P.L. 101-234, §202(a), struck out "(other than costs relating to the amendments made by the Medicare Catastrophic Coverage Act of 1988)", effective January 1, 1990, and applicable to premiums for months beginning after December 31, 1989.

[422] P.L. 101-234, §202(a), struck out ", but shall not take into account any amounts in the Trust Fund that may be attributable to receipts or outlays relating to the Medicare Catastrophic Coverage Account", effective January 1, 1990, and applicable to premiums for months beginning after December 31, 1989.

[423] P.L. 101-234, §202(a), struck out ", (e), and (g)" and substituted "and (e)", effective January 1, 1990, and applicable to premiums for months beginning after December 31, 1989.

[424] P.L. 101-234, §202(a), struck out "subsections (e) and (g)" and substituted "subsection (e)", effective January 1, 1990, and applicable to premiums for months beginning after December 31, 1989.

estimates to be necessary so that the aggregate amount for such calendar year with respect to disabled enrollees under age 65 which[425] will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees[426]. In calculating the monthly actuarial rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin[427].

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (a) or (e)[428] shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls)[429] (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account months[430] for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(1)(A)(v)[431] by reason of the individual's (or the individual's spouse's) current employment or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(1)(B)(iv)[432]). Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.

(c) If any monthly premium determined under the foregoing provisions of this section is not a multiple of 10 cents, such premium shall be rounded to the nearest multiple of 10 cents.

(d) For purposes of subsection (b) (and section 1837(g)(1)), an individual's "continuous period of eligibility" is the period beginning with the first day on which he is eligible to enroll under section 1836 and ending with his death; except that any period during all of which an individual satisfied paragraph (1) of section 1836 and which terminated in or before the month preceding the month in which he attained age 65 shall be a separate "continuous period of eligibility" with respect to such individual (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this section).

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[425] As in original.

[426] P.L. 101-234, §202(a), struck out "(other than costs relating to the amendments made by the Medicare Catastrophic Coverage Act of 1988)", effective January 1, 1990, and applicable to premiums for months beginning after December 31, 1989.

[427] P.L. 101-234, §202(a), struck out ", but shall not take into account any amounts in the Trust Fund that may be attributable to receipts or outlays relating to the Medicare Catastrophic Coverage Account", effective January 1, 1990, and applicable to premiums for months beginning after December 31, 1989.

[428] P.L. 101-234, §202(a), struck out "otherwise determined under this section (without regard to subsections (f) and (g)(6))" and substituted "determined under subsection (a) or (e)", effective January 1, 1990, and applicable to premiums for months beginning after December 31, 1989.

[429] As in original. Punctuation omitted.

[430] P.L. 101-239, §6202(c)(2), struck out "during which the individual has attained the age of 65 and", applicable to enrollments occurring after, and premiums for months after the calendar quarter beginning April 1, 1990.

[431] P.L. 101-239, §6202(b)(4)(C), struck out "1862(b)(3)(A)(iv)" and substituted "1862(b)(1)(A)(v)", applicable to items and services furnished after December 19, 1989.

[432] P.L. 101-239, §6202(b)(4)(C), struck out "1862(b)(4)(B)" and substituted "1862(b)(1)(B)(iv)", applicable to items and services furnished after December 19, 1989.

(e)(1)(A)[433] Notwithstanding the provisions of subsection (a)[434], the monthly premium for each individual enrolled under this part for each month after December 1983 and prior to January 1991[435] shall be an amount equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such month.

(B) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month in—

(i) 1991 shall be $29.90,
(ii) 1992 shall be $31.80,
(iii) 1993 shall be $36.60,
(iv) 1994 shall be $41.10, and
(v) 1995 shall be $46.10.[436]

(2) Any increases in premium amounts taking effect prior to January 1991[437] by reason of paragraph (1) shall be taken into account for purposes of determining increases thereafter under subsection (a)(3).

(f) For any calendar year after 1988, if an individual is entitled to monthly benefits under section 202 or 223 or to a monthly annuity under section 3(a), 4(a), or 4(f) of the Railroad Retirement Act of 1974[438] for November and December of the preceding year, and if the monthly premium of the individual under this section for December and for January is deducted from those benefits under section 1840(a)(1) or section 1840(b)(1), the monthly premium otherwise determined under this section for an individual for that year shall not be increased, pursuant to this subsection, to the extent that such increase would reduce the amount of benefits payable to that individual for that December below the amount of benefits payable to that individual for that November (after the deduction of the premium under this section). For purposes of this subsection, retroactive adjustments or payments and deductions on account of work shall not be taken into account in determining the monthly benefits to which an individual is entitled under section 202 or 223 or under the Railroad Retirement Act of 1974.

[(g) Repealed.[439]**]**

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[433] P.L. 101-508, §4301(1), redesignated paragraph (1) as subparagraph (A), effective November 5, 1990.

[434] P.L. 101-234, §202(a), struck out "except as provided in subsection (g),", effective January 1, 1990, and applicable to premiums for months beginning after December 31, 1989.

[435] P.L. 101-239, §6301, struck out "1990" and substituted "1991", effective December 19, 1989.

[436] P.L. 101-508, §4301(2), added subparagraph (B), effective November 5, 1990.

[437] P.L. 101-239, §6301, struck out "1990" and substituted "1991", effective December 19, 1989.

[438] P.L. 75-162.

[439] P.L. 101-234, §202(a), repealed subsection (g), effective January 1, 1990, and applicable to premiums for months beginning after December 31, 1989. **[**For subsection (g) as it formerly read, see Vol. III, P.L. 101-234.**]**

PAYMENT OF PREMIUMS

SEC. 1840. [42 U.S.C. 1395s] (a)(1) In the case of an individual who is entitled to monthly benefits under section 202 or 223, his monthly premiums under this part shall (except as provided in subsections (b)(1) and (c)) be collected by deducting the amount thereof from the amount of such monthly benefits. Such deduction shall be made in such manner and at such times as the Secretary shall by regulation prescribe.

(2) The Secretary of the Treasury shall, from time to time, transfer from the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates from benefits under section 202 or 223 which are payable from such Trust Fund. Such transfer shall be made on the basis of a certification by the Secretary of Health and Human Services and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

(b)(1) In the case of an individual who is entitled to receive for a month an annuity under the Railroad Retirement Act of 1974[440] (whether or not such individual is also entitled for such month to a monthly insurance benefit under section 202), his monthly premiums under this part shall (except as provided in subsection (c)) be collected by deducting the amount thereof from such annuity or pension. Such deduction shall be made in such manner and at such times as the Secretary shall by regulations prescribe. Such regulations shall be prescribed only after consultation with the Railroad Retirement Board.

(2) The Secretary of the Treasury shall, from time to time, transfer from the Railroad Retirement Account to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfers shall be made on the basis of a certification by the Railroad Retirement Board and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

(c) If an individual to whom subsection (a) or (b) applies estimates that the amount which will be available for deduction under such subsection for any premium payment period will be less than the amount of the monthly premiums for such period, he may (under regulations) pay to the Secretary such portion of the monthly premiums for such period as he desires.

(d)(1) In the case of an individual receiving an annuity under subchapter III of chapter 83 of title 5, United States Code, or any other law administered by the Director of the Office of Personnel Management providing retirement or survivorship protection, to whom neither subsection (a) nor subsection (b) applies, his monthly premiums under this part (and the monthly premiums of the spouse of such individual under this part if neither subsection (a) nor subsection (b) applies to such spouse and if such individual agrees) shall, upon notice from the Secretary of Health and Human Services to the Director of the Office of Personnel Management, be collected by deducting the amount thereof from each installment of such annuity. Such deduction shall be made in such manner and at such times as the Director of the Office of Personnel Management may determine. The Director of the Office of Personnel Management shall furnish such information as the Secretary of Health and Human Services may reasonably request in order to carry out his functions under this part with respect to individuals to whom this subsection applies. A plan described in section 8903 or 8903a of title 5, United States Code, may reimburse each annuitant enrolled in such plan an amount equal to the premiums paid by him under this part if such reimbursement is paid entirely from funds of such plan which are derived from sources other than the contributions described in section 8906 of such title.

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[440] P.L. 75-162 [as amended by P.L. 93-445].

(2) The Secretary of the Treasury shall, from time to time, but not less often than quarterly, transfer from the Civil Service Retirement and Disability Fund, or the account (if any) applicable in the case of such other law administered by the Director of the Office of Personnel Management, to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfer shall be made on the basis of a certification by the Director of the Office of Personnel Management and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

(e) In the case of an individual who participates in the insurance program established by this part but with respect to whom none of the preceding provisions of this section applies, or with respect to whom subsection (c) applies, the premiums shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe.

(f) Amounts paid to the Secretary under subsection (c) or (e) shall be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund.

(g) In the case of an individual who participates in the insurance program established by this part, premiums shall be payable for the period commencing with the first month of his coverage period and ending with the month in which he dies or, if earlier, in which his coverage under such program terminates.

(h) In the case of an individual who is enrolled under the program established by this part as a member of a coverage group to which an agreement with a State entered into pursuant to section 1843 is applicable, subsections (a), (b), (c), and (d) of this section shall not apply to his monthly premium for any month in his coverage period which is determined under section 1843(d).

[(i) Repealed.[441]]

FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

SEC. 1841. [42 U.S.C. 1395t] (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Supplementary Medical Insurance Trust Fund" (hereinafter in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part.[442]

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[441] P.L. 101-234, §202(a), repealed subsection (i), effective January 1, 1990, and applicable to premiums for months beginning after December 31, 1989. [For subsection (i) as it formerly read, see Vol. III, P.L. 101-234.]

(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the "Managing Trustee"). The Administrator of the Health Care Financing Administration shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Fund;

(2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years;

(3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

(4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund.[443] Such report shall also include an actuarial opinion by the Chief Actuarial Officer of the Health Care Financing Administration certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable. Such report shall be printed as a House document of the session of the Congress to which the report is made. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

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[442] P.L. 101-234, §202(a), struck out three sentences, effective January 1, 1990. Formerly, those three sentences read as follows: "There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the supplemental premiums imposed by section 59B of the Internal Revenue Code of 1986 which are attributable to the catastrophic coverage rate and which are not otherwise appropriated under section 1817A(a)(2) to the Federal Hospital Insurance Catastrophic Coverage Reserve Fund. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the premiums, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the premiums specified in such sentence. At the close of each year, the transfers under this subsection shall reflect all premiums under section 59B of the Internal Revenue Code of 1986 paid or deposited into the Treasury in the year.".

[443] P.L. 101-234, §202(a), struck out a sentence, effective January 1, 1990. That sentence read as follows: "Such report shall also identify (and treat separately) those receipts and outlays in the

(c) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under chapter 31 of title 31, United States Code, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

(d) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(e) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(f) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health and Human Services shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1870(b) of this Act. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the

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Trust Fund which are also receipts and outlays in the Medicare Catastrophic Coverage Account created under section 1841B.".

Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the Secretary of Health and Human Services shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1870(b) of this Act.

(g) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g)(1).

(h) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to pay the costs incurred by the Director of the Office of Personnel Management in making deductions pursuant to section 1840(d). During each fiscal year, or after the close of such fiscal year, the Director of the Office of Personnel Management shall certify to the Secretary the amount of the costs the Director incurred in making such deductions, and such certified amount shall be the basis for the amount of such costs certified by the Secretary to the Managing Trustee.

(i) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to pay the costs incurred by the Railroad Retirement Board for services performed pursuant to section 1840(b)(1) and section 1842(g). During each fiscal year or after the close of such fiscal year, the Railroad Retirement Board shall certify to the Secretary the amount of the costs it incurred in performing such services and such certified amount shall be the basis for the amount of such costs certified by the Secretary to the Managing Trustee.

[SEC. 1841A. Repealed.[444]]

[SEC. 1841B. Repealed.[445]]

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS[446]

SEC. 1842. [42 U.S.C. 1395u] (a) In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and with a view to furthering coordination of the administration of the benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1816 are in effect, which will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which involve payments for physicians' services on a reasonable charge basis, the Secretary shall to the extent possible enter into such contracts:

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[444] P.L. 101-234, §202(a), repealed §1841A, effective January 1, 1990. [For section 1841A as it formerly read, see Vol. III, P.L. 101-234.]

[445] P.L. 101-234, §202(a), repealed §1841B, effective January 1, 1990. [For section 1841B as it formerly read, see Vol. III, P.L. 101-234.]

[446] See Vol. II, P.L. 97-248, §118, with respect to funds for audit and medical claims review.

See Vol. II, P.L. 98-369, §2303(h), about simplification of procedures with respect to claims and payments for clinical diagnostic laboratory tests.

See Vol. II, P.L. 99-509, §9311(d)(3), with respect to the Secretary's responsibilities; and §9331(d) with respect to the development and use of the HCFA common procedure coding system.

P.L. 100-203, §4041(a)(3)(B)(i), struck out P.L. 99-509, §9332(a)(3), effective December 22, 1987. See Vol. II, P.L. 99-509, §9332(a)(4), as amended by P.L. 100-203, §4041(a)(3)(B)(ii) and (iii), with respect to carrier bonuses for good performance, effective December 22, 1987.

See Vol. II, P.L. 100-203, §4031(a)(3)(B) and §4032(c)(2), with respect to the responsibilities of the Secretary; §4031(c), with respect to budget considerations; and §4085(h), with respect to utilization screens for physician services provided to patients in rehabilitation hospitals.

P.L. 100-360, §202(e)(3)(B), was repealed by P.L. 101-234,§201(a)(1).

See Vol. II, P.L. 101-508, §4114, with respect to utilization screens for physician visits in rehabilitation hospitals; §4117(c), with respect to budget neutrality; and §4117(d), with respect to availability of procedures for modifying the fee schedule areas.

(1)(A) make determinations of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable);

(B) receive, disburse, and account for funds in making such payments; and

(C) make such audits of the records of providers of services as may be necessary to assure that proper payments are made under this part;

(2)(A) determine compliance with the requirements of section 1861(k) as to utilization review; and

(B) assist providers of services and other persons who furnish services for which payment may be made under this part in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization of services furnished by providers of services and other persons to individuals entitled to benefits under this part, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1861(k)(2)) to make reviews of utilization;

(3) serve as a channel of communication of information relating to the administration of this part; and

(4) otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this part.[447]

(b)(1) Contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

(2)(A) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent. The Secretary shall publish in the Federal Register standards and criteria for the efficient and effective performance of contract obligations under this section, and opportunity shall be provided for public comment prior to implementation. In establishing such standards and criteria, the Secretary shall provide a system to measure a carrier's performance of responsibilities described in paragraph (3)(H), subsection (h), and section 1845(e)(2)[448].[449] [450] The Secretary may not require, as a condition of entering into or renewing a contract under this section or under section 1871, that a carrier match data obtained other than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which section 1862(b) may apply.[451]

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[447] See Vol. II, P.L. 99-177, §256 , as amended by P.L. 100-119, with respect to special rules applicable to the Medicare program.

[448] P.L. 101-508, §4118(j)(2), struck out "1845(f)(2)" and substituted "1845(e)(2)", effective November 5, 1990.

(B) The Secretary shall establish standards for evaluating carriers' performance of reviews of initial carrier determinations and of fair hearings under paragraph (3)(C), under which a carrier is expected—

(i) to complete such reviews, within 45 days after the date of a request by an individual enrolled under this part for such a review, in 95 percent of such requests, and

(ii) to make a final determination, within 120 days after the date of receipt of a request by an individual enrolled under this part for a fair hearing under paragraph (3)(C), in 90 percent of such cases.

(C) In the case of residents of nursing facilities who receive services described in clause (i) or (ii) of section 1861(s)(2)(K) performed by a member of a team, the Secretary shall instruct carriers to develop mechanisms which permit routine payment under this part for up to 1.5 visits per month per resident. In the previous sentence, the term "team" refers to a physician and includes a physician assistant acting under the supervision of the physician or a nurse practitioner working in collaboration with that physician, or both.[452]

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1861(v));

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1870(f)) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which

(I) the reasonable charge is the full charge for the service, (II) the physician or other person furnishing such service agrees not to charge (and to refund amounts already collect-

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[449] P.L. 100-203, §4041(a)(3)(B)(i), struck out P.L. 99-509, §9332(a)(2), effective December 22, 1987. See Vol. II, P.L. 99-509, §9332(a)(4), as amended by P.L. 100-203, §4041(a)(3)(B)(ii) and (iii), with respect to performance measures.

[450] P.L. 100-360, §202(e)(3)(C) [as amended by P.L. 100-485, §608(d)(5)(F)], added a sentence, effective July 1, 1988.

P.L. 101-234, §201(a)(1), repealed P.L. 100-360, §202(e)(3)(C), effective January 1, 1990. That sentence formerly read as follows: "With respect to activities relating to implementation and operation (and related functions, including claims processing functions*) of the electronic system established under subsection (o)(4), the Secretary may enter into contracts with carriers under this section to perform such activities on a regional basis.".

*P.L. 100-485, §608(d)(5)(G), inserted ", including claims processing functions", effective as if included in the enactment of P.L. 100-360.

[451] P.L. 101-239, §6202(d)(2), added this sentence, applicable to agreements and contracts entered into or renewed on or after December 19, 1989.

[452] P.L. 101-239, §6114(c)(2), added subparagraph (C), applicable to services furnished on or after April 1, 1990.

P.L. 101-239, §6114(e), requires the Secretary to provide for at least 1 demonstration project under which, in the application of subparagraph (C) in one or more States, the limitation on the number of visits per month per resident would be applied on an average basis over the aggregate total of residents receiving services from members of the team.

ed) for services for which payment under this title is denied under section 1154(a)(2) by reason of a determination under section 1154(a)(1)(B), and (III) the physician or other person furnishing such service agrees not to charge (and to refund amounts already collected) for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1862(a), and if the individual to whom such service was furnished was without fault in incurring the expenses of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title (except in the case of physicians' services and ambulance service furnished as described in section 1862(a)(4), other than for purposes of section 1870(f));

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year);

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is at least $100, but less than $500, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part;

(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part;

(F) will take such action as may be necessary to assure that where payment under this part for a service rendered is on a charge basis, such payment shall be determined on the basis of the charge that is determined in accordance with this section on the basis of customary and prevailing charge levels in effect at the time the service was rendered or, in the case of services rendered more than 12 months before the year in which the bill is submitted or request for payment is made, on the basis of such levels in effect for the 12-month period preceding such year;

(G) will provide to each nonparticipating physician, at the beginning of each year, a list of the physician's limiting charges established under section 1848(g)(2)[453] for the year for the physicians' services mostly commonly furnished by that physician; and[454]

(H) if it makes determinations or payments with respect to physicians' services, will implement—

(i) programs to recruit and retain physicians as participating physicians in the area served by the carrier, including educational and outreach activities and the use of professional relations personnel to handle billing and other problems relating to payment of claims of participating physicians; and

(ii) programs to familiarize beneficiaries with the participating physician program and to assist such beneficiaries in locating participating physicians; and[455]

[(I) Repealed.[456]]

[(J) Repealed.[457]]

[(K) Repealed.[458]]

(L) will monitor and profile physicians' billing patterns within each area or locality and provide comparative data to physicians whose utilization patterns vary significantly from other physicians in the same payment area or locality;[459]

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the 12-month period ending on the June 30 last preceding the start of the calendar year in which the service is rendered. In the case of physicians' services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any twelve-month period (beginning after June 30, 1973) specified in clause (ii) of such sentence may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, or (with respect to physicians' services furnished in a year after 1987) the level determined under this sentence (or under any other provision of law affecting the prevailing charge level) for the previous year except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by year-to-year economic changes. With respect to power-operated wheelchairs for which payment may be made in accordance with section 1861(s)(6), charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The requirement in subparagraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (I) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health and Human Services performing functions under this title and acting within the scope of his or its authority, and (II) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected. Notwithstanding the provisions of the third and fourth sentences preceding this sentence, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such third and fourth sentences for any calendar year after 1974 shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975, and shall remain at such prevailing charge level until the prevailing charge for a year (as adjusted by economic index data) equals or exceeds such prevailing charge level. The amount of any charges for outpatient services which shall be considered reasonable shall be subject to the limitations established by regulations issued by the Secretary pursuant to section 1861(v)(1)(K), and in determining the reasonable charge for such services, the Secretary may limit such reasonable charge to a percentage of the amount of the prevailing charge for similar services furnished in a physician's office, taking into account the extent to which overhead costs associated with such outpatient services have been included in the reasonable cost or charge of the facility.[460]

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[453] P.L. 101-239, §6102(e)(2), struck out "maximum allowable actual charges (established under subsection (j)(1)(C))" and substituted "limiting charges established under subsection (j)(1)(C)", effective December 19, 1989.

P.L. 101-508, §4118(f)(2)(B), struck out "subsection (j)(1)(C)" and substituted "section 1848(g)(2)", effective January 1, 1991.

[454] P.L. 101-234, §201(a)(1), inserted "and".

[455] P.L. 101-234, §201(a)(1), struck out "and".

P.L. 101-234, §201(a)(1), inserted "and".

[456] P.L. 101-234, §201(a)(1), repealed subparagraph (I), effective January 1, 1990. [For subparagraph (I) as it formerly read, see Vol. III, P.L. 101-234.]

[457] P.L. 101-234, §201(a)(1), repealed subparagraph (J), effective January 1, 1990. [For subparagraph (J) as it formerly read, see Vol. III, P.L. 101-234.]

[458] P.L. 101-234, §201(a)(1), repealed subparagraph (K), effective January 1, 1990. [For subparagraph (K) as it formerly read, see Vol. III, P.L. 101-234.]

[459] P.L. 101-239, §6102(b)(3), added subparagraph (L), effective December 19, 1989.

(4)(A)(i) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 15-month period beginning July 1, 1984, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

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[460] See Vol. II, P.L. 99-509, §9331(c)(4) through (6), with respect to a study and limitation on changes in the Medicare economic index.

(ii)(I) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

(II) In determining the prevailing charge levels under the fourth sentence of paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall permit an additional one percentage point increase in the increase otherwise permitted under that sentence.

(iii) In determining the maximum allowable prevailing charges which may be recognized consistent with the index described in the fourth sentence of paragraph (3) for physicians' services furnished on or after January 1, 1987, by participating physicians, the Secretary shall treat the maximum allowable prevailing charges recognized as of December 31, 1986, under such sentence with respect to participating physicians as having been justified by economic changes.

(iv) The reasonable charge for physicians' services furnished on or after January 1, 1987, and before January 1, 1992,[461] by a nonparticipating physician shall be no greater than the applicable percent of the prevailing charge levels established under the third and fourth sentences of paragraph (3) (or under any other applicable provision of law affecting the prevailing charge level). In the previous sentence, the term "applicable percent" means for services furnished (I) on or after January 1, 1987, and before April 1, 1988, 96 percent, (II) on or after April 1, 1988, and before January 1, 1989, 95.5 percent, and (III) on or after January 1, 1989, 95 percent.

(v) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 3-month period beginning January 1, 1988, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning January 1, 1987.

(vi) Before each year (beginning with 1989), the Secretary shall establish a prevailing charge floor for primary care services (as defined in subsection (i)(4)) equal to 60[462] percent of the estimated average prevailing charge levels based on the best available data (determined, under the third and fourth sentences of paragraph (3) and under paragraph (4), without regard to this clause and without regard to physician specialty) for such service for all localities in the United States (weighted by the relative frequency of the service in each locality) for the year.

(vii) Beginning with 1987, the percentage increase in the MEI (as defined in subsection (i)(3)) for each year shall be the same for nonparticipating physicians as for participating physicians.

(B)(i) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 15-month period beginning

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[461] P.L. 101-239, §6102(e)(3), inserted "and before January 1, 1992,", effective for physicians' services furnished on or after January 1, 1992.

[462] P.L. 101-508, §4105(b)(1), struck out "50" and substituted "60", applicable to services furnished on or after January 1, 1991.

July 1, 1984, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983.

(ii) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services—

(I) if the physician was not a participating physician at any time during the 12-month period beginning on October 1, 1984, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983, and

(II) if the physician was a participating physician at any time during the 12-month period beginning on October 1, 1984, the physician's customary charges shall be determined based upon the physician's actual charges billed during the 12-month period ending on March 31, 1985.

(iii) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 3-month period beginning January 1, 1988, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning January 1, 1987.

(iv) In determining the reasonable charge under paragraph (3) for physicians' services (other than primary care services, as defined in subsection (i)(4)) furnished during 1991, the customary charges shall be the same customary charges as were recognized under this section for the 9-month period beginning April 1, 1990. In a case in which subparagraph (F) applies (relating to new physicians) so as to limit the customary charges of a physician during 1990 to a percent of prevailing charges, the previous sentence shall not prevent such limit on customary charges under such subparagraph from increasing in 1991 to a higher percent of such prevailing charges.[463]

(C) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during periods beginning after September 30, 1985, the Secretary shall treat the level as set under subparagraph (A)(i) as having fully provided for the economic changes which would have been taken into account but for the limitations contained in subparagraph (A)(i).

(D)(i) In determining the customary charges for physicians' services furnished during the 8-month period beginning May 1, 1986, or the 12-month period beginning January 1, 1987, by a physician who was not a participating physician (as defined in subsection (h)(1)) on September 30, 1985, the Secretary shall not recognize increases in actual charges for services furnished during the 15-month period beginning on July 1, 1984, above the level of the physician's actual charges billed in the 3-month period ending on June 30, 1984.

(ii) In determining the customary charges for physicians' services furnished during the 12-month period beginning January 1, 1987, by a physician who is not a participating physician (as defined in subsection (h)(1)) on April 30, 1986, the Secretary shall not recognize increases in actual charges for services furnished during the 7-month period beginning on October 1, 1985, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984.

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[463] P.L. 101-508, §4105(a)(2), added clause (iv), effective November 5, 1990.

(iii) In determining the customary charges for physicians' services furnished during the 12-month period beginning January 1, 1987, or January 1, 1988, by a physician who is not a participating physician (as defined in subsection (h)(1)) on December 31, 1986, the Secretary shall not recognize increases in actual charges for services furnished during the 8-month period beginning on May 1, 1986, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984.

(iv) In determining the customary charges for a physicians' service furnished on or after January 1, 1988, if a physician was a nonparticipating physician in a previous year (beginning with 1987), the Secretary shall not recognize any amount of such actual charges (for that service furnished during such previous year) that exceeds the maximum allowable actual charge for such service established under subsection (j)(1)(C).

(E)(i) For purposes of this part for physicians' services furnished in 1987, the percentage increase in the MEI is 3.2 percent.

(ii) For purposes of this part for physicians' services furnished in 1988, on or after April 1, the percentage increase in the MEI is—

(I) 3.6 percent for primary care services (as defined in subsection (i)(4)), and

(II) 1 percent for other physicians' services.

(iii) For purposes of this part for physicians' services furnished in 1989, the percentage increase in the MEI is—

(I) 3.0 percent for primary care services, and

(II) 1 percent for other physicians' services.[464]

(iv) For purposes of this part for items and services furnished in 1990, after March 31, 1990, the percentage increase in the MEI is—

(I) 0 percent for radiology services, for anesthesia services, and for other services specified in the list referred to in paragraph (14)(C)(i)[465],

(II) 2 percent for other services (other than primary care services), and

(III) such percentage increase in the MEI (as defined in subsection (i)(3)) as would be otherwise determined for primary care services (as defined in subsection (i)(4)).[466]

(v) For purposes of this part for items and services furnished in 1991, the percentage increase in the MEI is—

(I) 0 percent for services (other than primary care services), and

(II) 2 percent for primary care services (as defined in subsection (i)(4)).[467]

(F)(i) In the case of[468] professional services of a health care practitioner (other than primary care services and other than services furnished in a rural area (as defined in section 1886(d)(2)(D)) that is designated, under section 332(a)(1)(A) of the Public Health Service Act[469], as a health professional[470] shortage area) furnished during the[471] practitioner's first through fourth years of practice (if payment for those services is made separately under this part and on other than a cost-related basis), the prevailing charge or fee schedule amount to be applied under this part shall be 80 percent for the first year of practice, 85 percent for the second year of practice, 90 percent for the third year of practice, and 95 percent for the fourth year of practice, of the prevailing charge or fee schedule amount for that service under the other provisions of this part.

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[464] For physician services furnished on or after April 1, 1990, and before January 1, 1991, the increase for primary care services will be 4.2 percent and for other services it will be 2.0 percent. (55 FR 3487)

[465] P.L. 101-508, §4118(a)(2), struck out "Table #2 in the Joint Explanatory Statement of the Committee of Conference submitted with the Conference Report to accompany H.R. 3299 (the 'Omnibus Budget Reconciliation Act of 1989'), 101st Congress" and substituted "the list referred to in paragraph (14)(C)(i)", applicable to services furnished after March 1990.

[466] P.L. 101-239, §6107(b), added clause (iv), effective December 19, 1989.

[467] P.L. 101-508, §4105(a)(1), added clause (v), effective November 5, 1990.

[468] P.L. 101-508, §4106(b)(2)(A), struck out "physicians' services and", applicable to services furnished after 1991.

(ii) For purposes of clause (i):

(I) The term "health care practitioner" means a physician assistant, certified nurse-midwife, qualified psychologist, nurse practitioner, clinical social worker, physical therapist, occupational therapist, respiratory therapist, certified registered nurse anesthetist, or any other practitioner as may be specified by the Secretary.

(II) The term "first year of practice" means, with respect to a[472] practitioner, the first calendar year during the first 6 months of which the[473] practitioner furnishes professional services for which payment is made under this part, and includes any period before such year.

(III) The terms "second year of practice", "third year of practice", and "fourth year of practice" mean the second, third, and fourth calendar years, respectively, following the first year of practice.[474]

(5) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the insurance program established by this part.

(6) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that (A) payment may be made (i) to the employer of such physician or other person if such physician or other person is required as a condition of his employ-

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[469] P.L. 78-410.

[470] P.L. 101-597, §401(c)(2), struck out "manpower" and substituted "professional", effective November 16, 1990.

[471] P.L. 101-508, §4106(b)(2)(B), struck out "physician's or", applicable to services furnished after 1991.

[472] P.L. 101-508, §4106(b)(2)(C), struck out "physician or", applicable to services furnished after 1991.

[473] P.L. 101-508, §4106(b)(2)(C), struck out "physician or", applicable to services furnished after 1991.

[474] P.L. 101-508, §4106(a)(1), amended subparagraph (F) in its entirety. For the effective date, see Vol. II, P.L. 101-508, §4106(d)(1). **[**For subparagraph (F) as it formerly read, see Vol. III, P.L. 101-508.**]**

ment to turn over his fee for such service to his employer, or (ii) (where the service was provided in a hospital, rural primary care hospital,[475] clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service, (B) payment may be made to an entity (i) which provides coverage of the services under a health benefits plan, but only to the extent that payment is not made under this part, (ii) which has paid the person who provided the service an amount (including the amount payable under this part) which that person has accepted as payment in full for the service, and (iii) to which the individual has agreed in writing that payment may be made under this part,[476] (C) in the case of services described in clauses (i), (ii), or (iv) of[477] section 1861(s)(2)(K) payment shall be made to the employer of the physician assistant or nurse practitioner[478] involved, and (D) payment may be made to a physician who arranges for visit services (including emergency visits and related services) to be provided to an individual by a second physician on an occasional, reciprocal basis if (i) the first physician is unavailable to provide the visit services, (ii) the individual has arranged or seeks to receive the visit services from the first physician, (iii) the claim form submitted to the carrier includes the second physician's unique identifier (provided under the system established under subsection (r)) and indicates that the claim is for such a "covered visit service (and related services)", and (iv) the visit services are not provided by the second physician over a continuous period of longer than 60 days[479]. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

(7)(A) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), the carrier shall not provide (except on the basis described in subparagraph (C)) for payment for such services under this part—

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[475] P.L. 101-239, §6003(g)(3)(D)(ix), inserted "rural primary care hospital,", effective December 19, 1989.

[476] P.L. 101-508, §4110(a)(1), struck out "and".

[477] P.L. 101-508, §4155(c), inserted "clauses (i), (ii), or (iv) of", applicable to services furnished on or after January 1, 1991.

[478] P.L. 101-239, §6114(c)(1), inserted "or nurse practitioner", applicable to services furnished on or after April 1, 1990.

[479] P.L. 101-508, §4110(a)(2), inserted ", and" and subparagraph (D), applicable to services furnished on or after February 1, 1991.

(i) unless—

(I) the physician renders sufficient personal and identifiable physicians' services to the patient to exercise full, personal control over the management of the portion of the case for which the payment is sought,

(II) the services are of the same character as the services the physician furnishes to patients not entitled to benefits under this title, and

(III) at least 25 percent of the hospital's patients (during a representative past period, as determined by the Secretary) who were not entitled to benefits under this title and who were furnished services described in subclauses (I) and (II) paid all or a substantial part of charges (other than nominal charges) imposed for such services; and

(ii) to the extent that the payment is based upon a reasonable charge for the services in excess of the customary charge as determined in accordance with subparagraph (B).

(B) The customary charge for such services in a hospital shall be determined in accordance with regulations issued by the Secretary and taking into account the following factors:

(i) In the case of a physician who is not a teaching physician (as defined by the Secretary), the carrier shall take into account the amounts the physician charges for similar services in the physician's practice outside the teaching setting.

(ii) In the case of a teaching physician, if the hospital, its physicians, or other appropriate billing entity has established one or more schedules of charges which are collected for medical and surgical services, the carrier shall base payment under this title on the greatest of—

(I) the charges (other than nominal charges) which are most frequently collected in full or substantial part with respect to patients who were not entitled to benefits under this title and who were furnished services described in subclauses (I) and (II) of subparagraph (A)(i),

(II) the mean of the charges (other than nominal charges) which were collected in full or substantial part with respect to such patients, or

(III) 85 percent of the prevailing charges paid for similar services in the same locality.

(iii) If all the teaching physicians in a hospital agree to have payment made for all of their physicians' services under this part furnished to patients in such hospital on an assignment-related basis, the customary charge for such services shall be equal to 90 percent of the prevailing charges paid for similar services in the same locality.

(C) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), if the conditions described in subclauses (I) and (II) of subparagraph (A)(i) are met and if the physician elects payment to be determined under this subparagraph, the carrier shall provide for payment for such services under this part on the basis of regulations of the Secretary governing reimbursement for the services of hospital-based physicians (and not on any other basis).

(D)(i) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), no payment shall be made under this part for services of assistants at surgery with respect to a surgical procedure if such hospital has a training program relating to the medical specialty required for such surgical procedure and a qualified individual on the staff of the hospital is available to provide such services; except that payment may be made under this part for such services, to the extent that such payment is otherwise allowed under this paragraph, if such services, as determined under regulations of the Secretary—

(I) are required due to exceptional medical circumstances,

(II) are performed by team physicians needed to perform complex medical procedures, or

(III) constitute concurrent medical care relating to a medical condition which requires the presence of, and active care by, a physician of another specialty during surgery,

and under such other circumstances as the Secretary determines by regulation to be appropriate.

(ii) For purposes of this subparagraph, the term "assistant at surgery" means a physician who actively assists the physician in charge of a case in performing a surgical procedure.

(iii) The Secretary shall determine appropriate methods of reimbursement of assistants at surgery where such services are reimbursable under this part.

(8)(A) The Secretary by regulation shall—

(i) describe the factors to be used in determining the cases (of particular items or services) in which the application of this subsection results in the determination of a reasonable charge that, by reason of its grossly excessive or grossly deficient amount, is not inherently reasonable, and

(ii) provide in those cases for the factors that will be considered in establishing a reasonable charge that is realistic and equitable.

(B)(i) The Secretary may provide for an increase or decrease in the reasonable charge otherwise recognized under this section with respect to a specific physicians' service only in accordance with the criteria set forth in subparagraph (A) and with the succeeding provisions of this paragraph.

(ii) The factors described pursuant to subparagraph (A)(i) with respect to payment for physicians' services shall include, but need not be limited to, the following:

(I) Prevailing charges for a service in a particular locality are significantly in excess of or below prevailing charges in other comparable localities, taking into account the relative costs of furnishing the services in the different localities.

(II) The programs established under this title and title XIX are the sole or primary sources of payment for a service.

(III) The marketplace for a service is not truly competitive because of a limited number of physicians who perform that service.

(IV) There have been increases in charges for a service that cannot be explained by inflation or technology.

(V) The charges do not reflect changing technology, increased facility with that technology, or reductions in acquisition or production costs.

(VI) The prevailing charges for a service under this part are substantially higher or lower than the payments made for the service by other purchasers in the same locality.

(iii) In applying subparagraph (A), the Secretary may compare—

(I) the charges and resource costs for related procedures,

(II) charges and resource costs for the procedure over a period of time,

(III) charges for a procedure in different geographic areas, and

(IV) the charges and allowed payments for a procedure under this part and by other payors.

(iv) The factors considered under subparagraph (A)(ii) shall take into account regional differences in fees, unless there is substantial economic justification for a uniform fee or a uniform payment limit. Such substantial economic justification must be explained by the Secretary in the notice and final determination required by paragraph (9).

(v) An adjustment under clause (i) on the basis of a comparison of the prevailing charges in different localities may be made only if the Secretary determines that the prevailing charge allowed in one locality is out of line with prevailing charges allowed in other localities after accounting for differences in practice costs.

(vi) In this subparagraph, "resource costs" include factors such as the time required to provide a procedure (including pre-procedure evaluation and post-procedure follow-up), the complexity of the procedure, the training required to perform the procedure, and the risk involved in the procedure.

(C) In determining whether to adjust payment rates under subparagraph (B)(i), the Secretary shall consider the potential impacts on quality, access, and beneficiary liability of the adjustment, including the likely effects on assignment rates, reasonable charge reductions on unassigned claims, and participation rates of physicians.[480]

(9)(A) In the case of any physicians' service with respect to which the Secretary—

(i) determines, after appropriate consultation with representatives of the physicians likely to be affected by any change in the reasonable charge, that the application of this subsection results in the determination of a reasonable charge that, by reason of its grossly excessive or grossly deficient amount, is not inherently reasonable, and

(ii) proposes to establish a reasonable charge that is realistic and equitable or a methodology for arriving at such a charge,

the Secretary shall publish notice of such proposal in the Federal Register.

(B) A notice required by subparagraph (A) shall—

(i) specify the charge or methodology proposed to be established with respect to a service and shall explain the factors and data that the Secretary took into account in determining the charge or methodology so specified, and

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[480] See Vol. II, P.L. 99-509, §9334(b)(2), with respect to patient protections.

(ii) explain the potential impacts described in paragraph (8)(C).

(C) After publication of the notice required by subparagraph (A), the Secretary shall allow not less than 60 days for public comment on the proposal.

(D) In addition to carrying out its functions under section 1845, the Physician Payment Review Commission (in this paragraph referred to as the "Commission") shall comment on any such proposal within the period of comment allowed by the Secretary pursuant to subparagraph (C).

(E)(i) Taking into consideration the comments made by the Commission and the public, the Secretary shall publish in the Federal Register a final determination with respect to the reasonable charge or methodology to be established with respect to the service.

(ii) A final determination published pursuant to clause (i) shall explain the factors and data that the Secretary took into consideration in making the final determination, and shall include and respond to the comments made by the Commission pursuant to subparagraph (D).

(10)(A)(i) In determining the reasonable charge for procedures described in subparagraph (B) and performed during the 9-month period beginning on April 1, 1988, the prevailing charge for such procedure shall be the prevailing charge otherwise recognized for such procedure for 1987—

(I) subject to clause (iii), reduced by 2.0 percent, and

(II) further reduced by the applicable percentage specified in clause (ii).

(ii) For purposes of clause (i), the applicable percentage specified in this clause is—

(I) 15 percent, in the case of a prevailing charge otherwise recognized (without regard to this paragraph and determined without regard to physician specialty) that is at least 150 percent of the weighted national average (as determined by the Secretary) of such prevailing charges for such procedure for all localities in the United States for 1987;

(II) 0 percent, in the case of a prevailing charge that does not exceed 85 percent of such weighted national average; and

(III) in the case of any other prevailing charge, a percent determined on the basis of a straight-line sliding scale, equal to 3/13 of a percentage point for each percent by which the prevailing charge exceeds 85 percent of such weighted national average.

(iii) In no case shall the reduction under clause (i) for a procedure result in a prevailing charge in a locality for 1988 which is less than 85 percent of the Secretary's estimate of the weighted national average of such prevailing charges for such procedure for all localities in the United States for 1987 (based upon the best available data and determined without regard to physician specialty) after making the reduction described in clause (i)(I).

(B) The procedures described in this subparagraph are as follows: bronchoscopy, carpal tunnel repair, cataract surgery (including subsequent insertion of an intraocular lens), coronary artery bypass surgery, diagnostic and/or therapeutic dilation and curettage, knee arthroscopy, knee arthroplasty, pacemaker implantation surgery, total hip replacement, suprapubic prostatectomy, transurethral resection of the prostate, and upper gastrointestinal endoscopy.

(C) In the case of a reduction in the reasonable charge for a physicians' service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, after the effective date of such reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).

(D) There shall be no administrative or judicial review under section 1869 or otherwise of any determination under subparagraph (A) or under paragraph (11)(B)(ii).

(11)(A) In providing payment for cataract eyeglasses and cataract contact lenses, and professional services relating to them, under this part, each carrier shall—

(i) provide for separate determinations of the payment amount for the eyeglasses and lenses and of the payment amount for the professional services of a physician (as defined in section 1861(r)), and

(ii) not recognize as reasonable for such eyeglasses and lenses more than such amount as the Secretary establishes in guidelines relating to the inherent reasonableness of charges for such eyeglasses and lenses.[481]

(B)(i) In determining the reasonable charge under paragraph (3) for a cataract surgical procedure, subject to clause (ii), the prevailing charge for such procedure otherwise recognized for participating and nonparticipating physicians shall be reduced by 10 percent with respect to procedures performed in 1987.

(ii) In no case shall the reduction under clause (i) for a surgical procedure result in a prevailing charge in a locality for a year which is less than 75 percent of the weighted national average of such prevailing charges for such procedure for all the localities in the United States for 1986.

(C)(i) The prevailing charge level determined with respect to A-mode ophthalmic ultrasound procedures may not exceed 5 percent of the prevailing charge level established with respect to extracapsular cataract removal with lens insertion.

(ii) The reasonable charge for an intraocular lens inserted during or subsequent to cataract surgery in a physician's office may not exceed the actual acquisition cost for the lens (taking into account any discount) plus a handling fee (not to exceed 5 percent of such actual acquisition cost).

(D) In the case of a reduction in the reasonable charge for a physicians' service or item under subparagraph (B) or (C), if a nonparticipating physician furnishes the service or item to an individual entitled to benefits under this part after the effective date of such reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).

(12)(A) With respect to services described in clauses (i), (ii), or (iv) of[482] section 1861(s)(2)(K) (relating to a[483] physician assistants and nurse practitioners [484])—

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[481] See Vol. II, P.L. 99-272, §9304(b), with respect to computation of customary charges for certain former hospital-compensated physicians.

[482] P.L. 101-508, §4155(c), inserted "clauses (i), (ii), or (iv) of", applicable to services furnished on or after January 1, 1991.

[483] As in original.

[484] P.L. 101-239, §6114(b), struck out "assistant acting under the supervision of a physician" and substituted "assistants and nurse practitioners", applicable to services furnished on or after April 1, 1990.

(i) payment under this part may only be made on an assignment-related basis; and

(ii) the prevailing charges determined under paragraph (3) shall not exceed—

(I) in the case of services performed as an assistant at surgery, 65 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, or

(II) in other cases, the applicable percentage (as defined in subparagraph (B)) of the prevailing charge rate determined for such services (or, for services furnished on or after January 1, 1992, the fee schedule amount specified in section 1848[485])[486] performed by physicians who are not specialists.

(B) In subparagraph (A)(ii)(II), the term "applicable percentage" means—

(i) 75 percent in the case of services performed (other than as an assistant at surgery) in a hospital, and

(ii) 85 percent in the case of other services.

(C) Except for deductible and coinsurance amounts applicable under section 1833, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in clauses (i), (ii), or (iv) of[487] section 1861(s)(2)(K) in violation of subparagraph (A)(i) is subject to a civil money penalty of not to exceed $2,000 for each such bill or request. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(13)(A) In determining the reasonable charge under paragraph (3) of a physician for medical direction of two or more nurse anesthetists performing, on or after April 1, 1988, and before January 1, 1996[488], anesthesia services in whole or in part concurrently, the number of base units which may be recognized with respect to such medical direction for each concurrent procedure (other than cataract surgery or an iridectomy) shall be reduced by—

(i) 10 percent, in the case of medical direction of 2 nurse anesthetists concurrently,

(ii) 25 percent, in the case of medical direction of 3 nurse anesthetists concurrently, and

(iii) 40 percent, in the case of medical direction of 4 nurse anesthetists concurrently.

(B) In determining the reasonable charge under paragraph (3) of a physician for medical direction of two or more nurse anesthetists performing, on or after January 1, 1989, and before January 1, 1996[489], anesthesia services in whole or in part concurrently, the number of base units which may be recognized with respect to such medical direction for each concurrent cataract surgery or iridectomy procedure shall be reduced by 10 percent.

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[485] P.L. 101-508, §4118(f)(2)(C), struck out ", as the case may be", effective November 5, 1990.

[486] P.L. 101-239, §6102(e)(4), inserted "(or, for services furnished on or after January 1, 1992, the fee schedule amount specified in section 1848, as the case may be)" after "rate determined* for such services", effective December 19, 1989.

*P.L. 101-239, §6102(e)(4) [as amended by P.L. 101-508, §4118(f)(2)(A)], inserted "determined", effective as if included in P.L. 101-239.

[487] P.L. 101-508, §4155(c), inserted "clauses (i), (ii), or (iv) of", applicable to services furnished on or after January 1, 1991.

[488] P.L. 101-508, §4103(b), struck out "1991" and substituted "1996", effective November 5, 1990.

[489] P.L. 101-508, §4103(b), struck out "1991" and substituted "1996", effective November 5, 1990.

(C) The Secretary shall require claims for physicians' services for medical direction of nurse anesthetists during the periods in which the provisions of subparagraph (A) or (B) apply to indicate the number of such anesthetists being medically directed concurrently at any time during the procedure, the name of each nurse anesthetist being directed, and the type of procedure for which the services are provided.[490]

(14)(A)(i)[491] In determining the reasonable charge for a physicians' service specified in subparagraph (C)(i) and furnished during the 9-month period beginning on April 1, 1990, the prevailing charge for such service shall be the prevailing charge otherwise recognized for such service for 1989 reduced by 15 percent or, if less, 1/3 of the percent (if any) by which the prevailing charge otherwise applied in the locality in 1989 exceeds the locally-adjusted reduced prevailing amount (as determined under subparagraph (B)(i)) for the service.

(ii) In determining the reasonable charge for a physicians' service specified in subparagraph (C)(i) and furnished during 1991, the prevailing charge for such service shall be the prevailing charge otherwise recognized for such service for the period during 1990 beginning on April 1, reduced by the same amount as the amount of the reduction effected under this paragraph (as amended by the Omnibus Budget Reconciliation Act of 1990[492]) for such service during such period.[493]

(B) For purposes of this paragraph:

(i) The "locally-adjusted reduced prevailing amount" for a locality for a physicians' service is equal to the product of—

(I) the reduced national weighted average prevailing charge for the service (specified under clause (ii)), and

(II) the adjustment factor (specified under clause (iii)) for the locality.

(ii) The "reduced national weighted average prevailing charge" for a physicians' service is equal to the national weighted average prevailing charge for the service (specified in subparagraph (C)(ii)) reduced by the percentage change (specified in subparagraph (C)(iii)) for the service.

(iii) The "adjustment factor", for a physicians' service for a locality, is the sum of—

(I) the practice expense component (percent), divided by 100, specified in appendix A (pages 187 through 194) of the Report of the Medicare and Medicaid Health Budget Reconciliation Amendments of 1989, prepared by the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives, (Committee Print 101-M, 101st Congress, 1st Session) for the service[494], multiplied by the geographic practice cost index value (specified in subparagraph (C)(iv)) for the locality, and

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[490] See Vol. II, P.L. 100-203, §4048(c), with respect to a study of prevailing charges for anesthesia services, and §4048(d), with respect to studies and reports which the Comptroller General shall make regarding anesthesia services and payments.

[491] P.L. 101-508, §4101(a)(1), redesignated subparagraph (A) as clause (i), effective November 5, 1990.

[492] P.L. 101-508.

[493] P.L. 101-508, §4101(a)(2), added clause (ii), effective November 5, 1990.

(II) 1 minus the practice expense component (percent), divided by 100[495].

(C) For purposes of this paragraph:

(i) The physicians' services specified in this clause are the procedures specified (by code and description) in the Overvalued Procedures List for Finance Committee, Revised September 20, 1989, prepared by the Physician Payment Review Commission[496] which specification is of physicians' services that have been identified as overvalued by at least 10 percent based on a comparison of payments for such services under a resource-based relative value scale and of the national average prevailing charges under this part.

(ii) The "national weighted average prevailing charge" specified in this clause, for a physicians' service specified in clause (i), is the national weighted average prevailing charge for the service in 1989 as determined by the Secretary using the best data available.

(iii) The "percentage change" specified in this clause, for a physicians' service specified in clause (i), is the percent difference (but expressed as a positive number) specified for the service in the list[497] referred to in clause (i).

(iv) The geographic practice cost index value specified in this clause for a locality is the Geographic Overhead Costs Index specified for the locality in table 1 of the September 1989 Supplement to the Geographic Medicare Economic Index: Alternative Approaches (prepared by the Urban Institute and the Center for Health Economics Research)[498].

(D) In the case of a reduction in the prevailing charge for a physicians' service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, after the effective date of such reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).[499]

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[494] P.L. 101-508, §4118(a)(1)(A), struck out "ratio for the service (specified in table #1* in the Joint Explanatory Statement referred to in subparagraph (C)(i))" and substituted "component (percent), divided by 100, specified in appendix A (pages 187 through 194) of the Report of the Medicare and Medicaid Health Budget Reconciliation Amendments of 1989, prepared by the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives, (Committee Print 101-M, 101st Congress, 1st Session) for the service", applicable to services furnished after March 1990.

*Executed as if "table #1" read "Table #1".

[495] P.L. 101-508, §4118(a)(1)(B), struck out "ratio" and substituted "component (percent), divided by 100", applicable to services furnished after March 1990.

[496] P.L. 101-508, §4118(a)(1)(C), struck out "physicians' services specified in Table #2 in the Joint Explanatory Statement of the Committee of Conference submitted with the Conference Report to accompany H.R. 3299 (the 'Omnibus Budget Reconciliation Act of 1989'), 101st Congress," and substituted "procedures specified (by code and description) in the Overvalued Procedures List for Finance Committee, Revised September 20, 1989, prepared by the Physician Payment Review Commission", applicable to services furnished after March 1990.

[497] P.L. 101-508, §4118(a)(1)(D), struck out " 'percent change' specified in this clause, for a physicians' service specified in clause (i), is the percent change specified for the service in table #2* in the Joint Explanatory Statement" and substituted " 'percentage change' specified in this clause, for a physicians' service specified in clause (i), is the percent difference (but expressed as a positive number) specified for the service in the list", applicable to services furnished after March 1990.

*Executed as if "table #2" read "Table #2".

[498] P.L. 101-508, §4118(a)(1)(E), struck out "such value specified for the locality in table #3* in the Joint Explanatory Statement referred to in clause (i)" and substituted "the Geographic Overhead Costs Index specified for the locality in table 1 of the September 1989 Supplement to the Geographic Medicare Economic Index: Alternative Approaches (prepared by the Urban Institute and the Center for Health Economics Research)", applicable to services furnished after March 1990.

*Executed as if "table #3" read "Table #3".

(15)(A) In determining the reasonable charge for surgery, radiology, and diagnostic physicians' services which the Secretary shall designate (based on their high volume of expenditures under this part) and for which the prevailing charge (but for this paragraph) differs by physician specialty, the prevailing charge for such a service may not exceed the prevailing charge or fee schedule amount for that specialty of physicians that furnish the service most frequently nationally.

(B) In the case of a reduction in the prevailing charge for a physician's service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, after the effective date of the reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).[500]

(16)(A) In determining the reasonable charge for all physicians' services other than physicians' services specified in subparagraph (B) furnished during 1991, the prevailing charge for a locality shall be 6.5 percent below the prevailing charges used in the locality under this part in 1990 after March 31.

(B) For purposes of subparagraph (A), the physicians' services specified in this subparagraph are as follows:

(i) Radiology, anesthesia and physician pathology services, the technical components of diagnostic tests specified in paragraph (17) and physicians' services specified in paragraph (14)(C)(i).

(ii) Primary care services specified in subsection (i)(4), hospital inpatient medical services, consultations, other visits, preventive medicine visits, psychiatric services, emergency care facility services, and critical care services.

(iii) Partial, simple and subcutaneous mastectomy; tendon sheath injections; small joint arthrocentesis; femoral fracture treatments; trochanteric fracture treatments; endotracheal intubation; thoracentesis; thoracostomy; lobectomy; aneurysm repair; enterectomy; colectomy; cholecystectomy; cystourethroscopy; transurethral fulguration; transurerethral resection; sacral laminectomy; tympanoplasty with mastoidectomy; and ophthalmoscopy.[501]

(18) With respect to payment under this part for the technical (as distinct from professional) component of diagnostic tests (other than clinical diagnostic laboratory tests and radiology services, including portable x-ray services) which the Secretary shall designate (based on their high volume of expenditures under this part), the reasonable charge for such technical component (including the applicable portion of a global service) may not exceed the national median of such charges for all localities, as estimated by the Secretary using the best available data.[502]

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[499] P.L. 101-239, §6104(a), added this paragraph, effective December 19, 1989.

[500] P.L. 101-239, §6108(b)(1), added this paragraph, applicable to procedures performed after March 31, 1990.

[501] P.L. 101-508, §4101(b)(1), added paragraph (16), effective November 5, 1990.

See Vol. II, P.L. 101-508, §4101(b)(2), with respect to the codes for the procedures specified in clauses (16)(B)(ii) and (iii).

[502] P.L. 101-508, §4108(a), added paragraph (18), applicable to tests and services furnished on or after January 1, 1991.

As in original; probably should be paragraph (17).

(c)(1)(A)[503] Any contract entered into with a carrier under this section shall provide for advances of funds to the carrier for the making of payments by it under this part, and[504] shall provide for payment of the cost of administration of the carrier, as determined by the Secretary to be necessary and proper for carrying out the functions covered by the contract. The Secretary shall provide that in determining a carrier's necessary and proper cost of administration, the Secretary shall, with respect to each contract, take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated carrier in carrying out the terms of its contract. The Secretary shall cause to have published in the Federal Register, by not later than September 1 before each fiscal year, data, standards, and methodology to be used to establish budgets for carriers under this section for that fiscal year, and shall cause to be published in the Federal Register for public comment, at least 90 days before such data, standards, and methodology are published, the data, standards, and methodology proposed to be used.

[(ii) Repealed.[505]]

(B) Of the amounts appropriated for administrative activities to carry out this part, the Secretary shall provide payments, totaling 1 percent of the total payments to carriers for claims processing in any fiscal year, to carriers under this section, to reward carriers for their success in increasing the proportion of physicians in the carrier's service area who are participating physicians or in increasing the proportion of total payments for physicians' services which are payments for such services rendered by participating physicians.[506]

(2)(A) Each[507] contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to not less than 95 percent of all claims submitted under this part—

(i) which are clean claims, and

(ii) for which payment is not made on a periodic interim payment basis,

within the applicable number of calendar days after the date on which the claim is received.

(B) In this paragraph:

(i) The term "clean claim" means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this part.

(ii) The term "applicable number of calendar days" means—

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[503] P.L. 101-234, §201(a)(1), struck out "(i)", effective January 1, 1990.

[504] P.L. 101-234, §201(a)(1), struck out ", except as provided in clause (ii),", effective January 1, 1990.

[505] P.L. 101-234, §201(a)(1), repealed clause (ii), effective January 1, 1990. [For clause (ii) as it formerly read, see Vol. III, P.L. 101-234.]

[506] See Vol. II, P.L. 99-509, §9332(a)(4)(C) [as amended by P.L. 100-203, §4041(a)(3)(B)(iii)], with respect to carrier bonuses.

[507] P.L. 100-360, §202(e)(5)(A) [as amended by P.L. 100-485, §608(d)(5)(H)(i)], struck out "Each" and substituted "Except as provided in paragraph (4), each", effective on January 1, 1991, but not to be construed as requiring payment before February 1, 1991.

P.L. 101-234, §201(a)(1), struck out "Except as provided in paragraph (4)*, each" and substituted "Each", effective January 1, 1990.

*P.L. 100-485, §608(d)(5)(H)(i), struck out "(3)" and substituted "(4)".

(I) with respect to claims received in the 12-month period beginning October 1, 1986, 30 calendar days,

(II) with respect to claims received in the 12-month period beginning October 1, 1987, 26 calendar days (or 19 calendar days with respect to claims submitted by participating physicians),

(III) with respect to claims received in the 12-month period beginning October 1, 1988, 25 calendar days (or 18 calendar days with respect to claims submitted by participating physicians), and

(IV) with respect to claims received in the 12-month period beginning October 1, 1989, and claims received in any succeeding 12-month period, 24 calendar days (or 17 calendar days with respect to claims submitted by participating physicians).

(C) If payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in clause (ii) of subparagraph (B)) after a clean claim (as defined in clause (i) of such subparagraph) is received, interest shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made.

(3)(A) Each[508] contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall provide that no payment shall be issued, mailed, or otherwise transmitted with respect to any claim submitted under this title within the applicable number of calendar days after the date on which the claim is received.

(B) In this paragraph, the term "applicable number of calendar days" means—

(i) with respect to claims received in the 3-month period beginning July 1, 1988, 10 days, and

(ii) with respect to claims received in the 12-month period beginning October 1, 1988, 14 days.

[(4) Repealed.[509]**]**

(d) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(e)(1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher

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[508] P.L. 100-360, §202(e)(5)(A) [as amended by P.L. 100-485, §608(d)(5)(H)(i)], struck out "Each" and substituted "Except as provided in paragraph (4), each", effective on January 1, 1991, but not to be construed as requiring payment before February 1, 1991.

P.L. 101-234, §201(a)(1), struck out "Except as provided in paragraph (4)[*], each" and substituted "Each", effective January 1, 1990.

[*] P.L. 100-485, §608(d)(5)(H)(i), struck out "(3)" and substituted "(4)".

[509] P.L. 101-234, §201(a)(1), repealed paragraph (4), effective January 1, 1990. **[**For paragraph (4) as it formerly read, see Vol. III, P.L. 101-234.**]**

signed by a certifying officer designated as provided in paragraph (1) of this subsection.

(3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

(f) For purposes of this part, the term "carrier" means—

(1) with respect to providers of services and other persons, a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization; and[510]

(2) with respect to providers of services only, any agency or organization (not described in paragraph (1)) with which an agreement is in effect under section 1816.[511]

[(3) Repealed.[512]]

(g) The Railroad Retirement Board shall, in accordance with such regulations as the Secretary may prescribe, contract with a carrier or carriers to perform the functions set out in this section with respect to individuals entitled to benefits as qualified railroad retirement beneficiaries pursuant to section 226(a) of this Act and section 7(d) of the Railroad Retirement Act of 1974[513].

(h)(1) Any physician or supplier may voluntarily enter into an agreement with the Secretary to become a participating physician or supplier. For purposes of this section, the term "participating physician or supplier" means a physician or supplier (excluding any provider of services) who, before the beginning of any year beginning with 1984, enters into an agreement with the Secretary which provides that such physician or supplier will accept payment under this part on an assignment-related basis for all items and services furnished to individuals enrolled under this part during such year[514]. In the case of a newly licensed physician or a physician who begins a practice in a new area, or in the case of a new supplier who begins a new business, or in such similar cases as the Secretary may specify, such physician or supplier may enter into such an agreement after the beginning of a year, for items and services furnished during the remainder of the year.

(2) Each carrier[515] having an agreement with the Secretary under subsection (a) shall maintain a toll-free telephone number or numbers at which individuals enrolled under this part may obtain the names, addresses, specialty, and telephone numbers of participating physicians and suppliers and may request a copy of an appropriate directory published under paragraph (4). Each such carrier shall, without charge, mail a copy of such directory upon such a request.

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[510] P.L. 101-234, §201(a)(1), inserted "and".

[511] P.L. 101-234, §201(a)(1), struck out "; and" and substituted a period.

[512] P.L. 101-234, §201(a)(1), repealed paragraph (3), effective January 1, 1990. [For paragraph (3) as it formerly read, see Vol. III, P.L. 101-234.]

[513] P.L. 75-162 [as amended by P.L. 93-445].

[514] P.L. 101-234, §201(a)(1), struck out ", except that, with respect to a supplier of covered outpatient drugs, the term 'participating supplier' means a participating pharmacy (as defined in subsection (o)(1))", effective January 1, 1990.

[515] P.L. 101-234, §201(a)(1), struck out "(other than a carrier described in subsection (f)(3))", effective January 1, 1990.

(3)(A) In any case in which a carrier having an agreement with the Secretary under subsection (a) is able to develop a system for the electronic transmission to such carrier of bills for services, such carrier shall establish direct lines for the electronic receipt of claims from participating physicians and suppliers.

(B) The Secretary shall establish a procedure whereby an individual enrolled under this part may assign, in an appropriate manner on the form claiming a benefit under this part for an item or service furnished by a participating physician or supplier, the individual's rights of payment under a medicare supplemental policy (described in section 1882(g)(1)) in which the individual is enrolled. In the case such an assignment is properly executed and a payment determination is made by a carrier with a contract under this section, the carrier shall transmit to the private entity issuing the medicare supplemental policy notice of such fact and shall include an explanation of benefits and any additional information that the Secretary may determine to be appropriate in order to enable the entity to decide whether (and the amount of) any payment is due under the policy. The Secretary may enter into agreements for the transmittal of such information to entities electronically. The Secretary shall impose user fees for the transmittal of information under this subparagraph by a carrier, whether electronically or otherwise, and such user fees shall be collected and retained by the carrier.[516]

(4) At the beginning of each year the Secretary shall publish directories (for appropriate local geographic areas) containing the name, address, and specialty of all participating physicians and suppliers (as defined in paragraph (1)) for that area for that year. Each directory shall be organized to make the most useful presentation of the information (as determined by the Secretary) for individuals enrolled under this part. Each participating physician directory for an area shall provide an alphabetical listing of all participating physicians practicing in the area and an alphabetical listing by locality and specialty of such physicians.[517]

(5)(A) The Secretary shall promptly notify individuals enrolled under this part through an annual mailing of the participation program under this subsection and the publication and availability of the directories and shall make the appropriate area directory or directories available in each district and branch office of the Social Security Administration, in the offices of carriers, and to senior citizen organizations.

(B) The annual notice provided under subparagraph (A) shall include—

(i) a description of the participation program,

(ii) an explanation of the advantages to beneficiaries of obtaining covered services through a participating physician or supplier,

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[516] P.L. 101-234, §201(a)(1), repealed P.L. 100-360, §202(e)(4)(B), with respect to the adjustment of carrier obligations; delay in application of coordinated benefits with medigap, effective January 1, 1990.

[517] P.L. 100-360, §202(c)(1)(B), added "In publishing directories under this paragraph, the Secretary shall provide for separate directories (wherever appropriate) for participating pharmacies.", applicable to items dispensed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out that sentence, effective January 1, 1990.

P.L. 101-239, §6102(e)(10), provides that, in applying paragraph (4) for services furnished on or after January 1, 1990, intermediate and comprehensive office visits for eye examinations and treatments (codes 92002 and 92004) shall be considered to be primary care services.

(iii) an explanation of the assistance offered by carriers in obtaining the names of participating physicians and suppliers, and

(iv) the toll-free telephone number under paragraph (2)(A) for inquiries concerning the program and for requests for free copies of appropriate directories.

(6) The Secretary shall provide that the directories shall be available for purchase by the public. The Secretary shall provide that each appropriate area directory is sent to each participating physician located in that area and that an appropriate number of copies of each such directory is sent to hospitals located in the area. Such copies shall be sent free of charge.

(7) The Secretary shall provide that each explanation of benefits provided under this part for services furnished in the United States, in conjunction with the payment of claims under section 1833(a)(1) (made other than on an assignment-related basis), shall include—

(A) a prominent reminder of the participating physician and supplier program established under this subsection (including the limitation on charges that may be imposed by such physicians and suppliers and a clear statement of any amounts charged for the particular items or services on the claim involved above the amount recognized under this part),

(B) the toll-free telephone number or numbers, maintained under paragraph (2), at which an individual enrolled under this part may obtain information on participating physicians and suppliers, and

(C) shall include (i) an offer of assistance to such an individual in obtaining the names of participating physicians of appropriate specialty and (ii) an offer to provide a free copy of the appropriate participating physician directory.

(i) For purposes of this title:

(1) A claim is considered to be paid on an "assignment-related basis" if the claim is paid on the basis of an assignment described in subsection (b)(3)(B)(ii), in accordance with subsection (b)(6)(B), or under the procedure described in section 1870(f)(1).[518]

(2) The term "participating physician" refers, with respect to the furnishing of services, to a physician who at the time of furnishing the services is a participating physician (under subsection (h)(1)), and the term "nonparticipating physician" refers, with respect to the furnishing of services, a[519] physician who at the time of furnishing the services is not a participating physician.

(3) The term "percentage increase in the MEI" means, with respect to physicians' services furnished in a year, the percentage increase in the medicare economic index (referred to in the fourth sentence of subsection (b)(3)) applicable to such services furnished as of the first day of that year.

(4) The term "primary care services" means physicians' services which constitute office medical services, emergency department services, home medical services, skilled nursing, intermedi-

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[518] See Vol. II, P.L. 99-272, §9301(b)(3), for the period for entering participation agreements.
See Vol. II, P.L. 100-203, §4041(a)(2), with respect to the extension of physician participation agreements and related provisions.

[519] Probably should read "to a".

ate care, and long-term care medical services, or nursing home, boarding home, domiciliary, or custodial care medical services.

(j)(1)(A) In the case of a physician who is not a participating physician for items and services furnished during a portion of the 30-month period beginning July 1, 1984, the Secretary shall monitor the physician's actual charges to individuals enrolled under this part for physicians' services during that portion of that period. If such physician knowingly and willfully bills individuals enrolled under this part for actual charges in excess of such physician's actual charges for the calendar quarter beginning on April 1, 1984, the Secretary may apply sanctions against such physician in accordance with paragraph (2).

(B)(i) During any period (on or after January 1, 1987, and before the date specified in clause (ii)), during which a physician is a nonparticipating physician, the Secretary shall monitor the actual charges of each such physician for physicians' services furnished to individuals enrolled under this part. If such physician knowingly and willfully bills on a repeated basis for such a service an actual charge in excess of the maximum allowable actual charge determined under subparagraph (C) for that service, the Secretary may apply sanctions against such physician in accordance with paragraph (2).

(ii) Clause (i) shall not apply to services furnished after December 31, 1990.[520]

(C)(i) For a particular physicians' service furnished by a nonparticipating physician to individuals enrolled under this part during a year, for purposes of subparagraph (B), the maximum allowable actual charge is determined as follows: If the physician's maximum allowable actual charge for that service in the previous year was—

(I) less than 115 percent of the applicable percent (as defined in subsection (b)(4)(A)(iv)) of the prevailing charge for the year and service involved, the maximum allowable actual charge for the year involved is the greater of the maximum allowable actual charge described in subclause (II) or the charge described in clause (ii), or

(II) equal to, or greater than, 115 percent of the applicable percent (as defined in subsection (b)(4)(A)(iv)) of the prevailing charge for the year and service involved, the maximum allowable actual charge is 101 percent of the physician's maximum allowable actual charge for the service for the previous year.

(ii) For purposes of clause (i)(I), the charge described in this clause for a particular physicians' service furnished in a year is the maximum allowable actual charge for the service of the physician for the previous year plus the product of (I) the applicable fraction (as defined in clause (iii)) and (II) the amount by which 115 percent of the prevailing charge for the year involved for such service furnished by nonparticipating physicians, exceeds the physician's maximum allowable actual charge for the service for the previous year.

(iii) In clause (ii), the "applicable fraction" is—

(I) for 1987, 1/4,

(II) for 1988, 1/3,

(III) for 1989, 1/2, and

(IV) for any subsequent year, 1.

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[520] P.L. 101-239, §6102(e)(9), struck out "the earlier of (I) December 31, 1990, or" and subclause (II) and substituted "December 31, 1990.", effective December 19, 1989. [For subclause (II) as it formerly read, see Vol. III, P.L. 101-239.]

(iv) For purposes of determining the maximum allowable actual charge under clauses (i) and (ii) for 1987, in the case of a physicians' service for which the physician has actual charges for the calendar quarter beginning on April 1, 1984, the "maximum allowable actual charge" for 1986 is the physician's actual charge for such service furnished during such quarter.

(v) For purposes of determining the maximum allowable actual charge under clauses (i) and (ii) for a year after 1986, in the case of a physicians' service for which the physician has no actual charges for the calendar quarter beginning on April 1, 1984, and for which a maximum allowable actual charge has not been previously established under this clause, the "maximum allowable actual charge" for the previous year shall be the 50th percentile of the customary charges for the service (weighted by frequency of the service) performed by nonparticipating physicians in the locality during the 12-month period ending June 30 of that previous year.

(vi) For purposes of this subparagraph, a "physician's actual charge" for a physicians' service furnished in a year or other period is the weighted average (or, at the option of the Secretary for a service furnished in the calendar quarter beginning April 1, 1984, the median) of the physician's charges for such service furnished in the year or other period.

(vii) In the case of a nonparticipating physician who was a participating physician during a previous period, for the purpose of computing the physician's maximum allowable actual charge during the physician's period of nonparticipation, the physician shall be deemed to have had a maximum allowable actual charge during the period of participation, and such deemed maximum allowable actual charge shall be determined according[521] to clauses (i) through (vi).

(viii) Notwithstanding any other provision of this subparagraph, the maximum allowable actual charge for a particular physician's service furnished by a nonparticipating physician to individuals enrolled under this part during the 3-month period beginning on January 1, 1988, shall be the amount determined under this subparagraph for 1987. The maximum allowable actual charge for any such service otherwise determined under this subparagraph for 1988 shall take effect on April 1, 1988.

(ix) If there is a reduction under subsection (b)(13) in the reasonable charge for medical direction furnished by a nonparticipating physician, the maximum allowable actual charge otherwise permitted under this subsection for such services shall be reduced in the same manner and in the same percentage as the reduction in such reasonable charge.

(D)(i) If an action described in clause (ii) results in a reduction in a reasonable charge for a physicians' service or item and a nonparticipating physician furnishes the service or item to an individual entitled to benefits under this part after the effective date of such action, the physician may not charge the individual more than 125 percent of the reduced payment allowance (as defined in clause (iii)) plus (for services or items furnished during the 12-month period (or

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[521] P.L. 101-234, §301(b)(2), struck out "accordingly" and substituted "according", effective December 13, 1989.

P.L. 101-234, §301(c)(2), made the same amendment, effective as if included in the enactment of P.L. 100-203.

9-month period in the case of an action described in clause (ii)(II)) beginning on the effective date of the action) 1/2 of the amount by which the physician's maximum allowable actual charge for the service or item for the previous 12-month period exceeds such 125 percent level.[522]

(ii) The first sentence of clause (i) shall apply to—

(I) an adjustment under subsection (b)(8)(B) (relating to inherent reasonableness),

(II) a reduction under subsection (b)(10)(A) or (b)(14)(A)[523] (relating to certain overpriced procedures),

(III) a reduction under subsection (b)(11)(B) (relating to certain cataract procedures),

(IV) a prevailing charge limit established under subsection (b)(11)(C)(i) or (b)(15)(A)[524],

(V) a reasonable charge limit established under subsection (b)(11)(C)(ii), and

(VI) an adjustment under section 1833(l)(3)(B) (relating to physician supervision of certified registered nurse anesthetists).

(iii) In clause (i), the term "reduced payment allowance" means, with respect to an action—

(I) under subsection (b)(8)(B), the inherently reasonable charge established under subsection (b)(8);

(II) under subsection (b)(10)(A), (b)(11)(B), (b)(11)(C)(i), (b)(14)(A)[525], or (b)(15)(A)[526] or under section 1833(l)(3)(B), the prevailing charge for the service after the action; or

(III) under subsection (b)(11)(C)(ii), the payment allowance established under such subsection.

(iv) If a physician knowingly and willfully bills in violation of clause (i) (whether or not such charge violates subparagraph (B)), the Secretary may apply sanctions against such physician in accordance with paragraph (2).

(v) Clause (i) shall not apply to items and services furnished after December 31, 1990.[527] [528]

(2) Subject to paragraph (3), the sanctions which the Secretary may apply under this paragraph[529] are—

(A) excluding a physician from participation in the programs under this Act for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1128, or

(B) civil monetary penalties and assessments, in the same manner as such penalties and assessments are authorized under section 1128A(a),[530] or both. The provisions of section 1128A (other than the first 2 sentences of subsection (a) and other than subsection (b)) shall apply to a civil money penalty and assessment under subparagraph (B) in the same manner as such provisions apply to a penalty, assessment, or proceeding under section 1128A(a), except to the extent such provisions are inconsistent with subparagraph (A) or paragraph (3).

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[522] See Vol. II, P.L. 100-203, §4063(d), with respect to establishing a reasonable charge limit.

[523] P.L. 101-239, §6104(b)(1), inserted "or (b)(14)(A)", effective December 19, 1989.

[524] P.L. 101-239, §6108(b)(2)(A), inserted "or (b)(15)(A)", applicable to procedures performed after March 31, 1990.

[525] P.L. 101-239, §6104(b)(2), struck out "or (b)(11)(C)(i)" and substituted "(b)(11)(C)(i), or (b)(14)(A)", effective December 19, 1989.

[526] P.L. 101-239, §6108(b)(2)(B), struck out "or (b)(14)(A)" and substituted "(b)(14)(A), or (b)(15)(A)", applicable to procedures performed after March 31, 1990.

[527] P.L. 101-239, §6102(e)(9), struck out "the earlier of (I) December 31, 1990, or" and subclause (II) and substituted "December 31, 1990.", effective December 19, 1989. [For subclause (II) as it formerly read, see Vol. III, P.L. 101-239.]

[528] See Vol. II, P.L. 99-509, §9334(b)(2), with respect to certain reductions in the reasonable charge for physicians' services.

[529] P.L. 99-509, §9320(e)(3), struck out "paragraph (1) or subsection (k)" and substituted "this paragraph". For the effective date, see Vol. II, P.L. 99-509, §9320(i), as amended by P.L. 100-485.

[530] P.L. 101-234, §301(b)(6), struck out "paragraphs" in "Section 1842(j)(2)(B)" and substituted "subsections", effective December 13, 1989. Impossible to execute.

P.L. 101-234, §301(d)(3), made the same amendment. Impossible to execute.

(3)(A) The Secretary may not exclude a physician pursuant to paragraph (2)(A) if such physician is a sole community physician or sole source of essential specialized services in a community.

(B) The Secretary shall take into account access of beneficiaries to physicians' services for which payment may be made under this part in determining whether to bar a physician from participation under paragraph (2)(A).

(4) The Secretary may, out of any civil monetary penalty or assessment collected from a physician pursuant to this subsection, make a payment to a beneficiary enrolled under this part in the nature of restitution for amounts paid by such beneficiary to such physician which was determined to be an excess charge under paragraph (1).[531]

(k)(1) If a physician knowingly and willfully presents or causes to be presented a claim or bills an individual enrolled under this part for charges for services as an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2) in the case of surgery performed on or after March 1, 1987.

(2) If a physician knowingly and willfully presents or causes to be presented a claim or bills an individual enrolled under this part for charges that includes[532] a charge for an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2) in the case of surgery performed on or after March 1, 1987.

(l)(1)(A) Subject to subparagraph (C), if—

(i) a nonparticipating physician furnishes services to an individual enrolled for benefits under this part,

(ii) payment for such services is not accepted on an assignment-related basis,

(iii)(I) a carrier determines under this part or a peer review organization determines under part B of title XI that payment may not be made by reason of section 1862(a)(1) because a service otherwise covered under this title is not reasonable and necessary under the standards described in that section or (II) payment under this title for such services is denied under section 1154(a)(2) by reason of a determination under section 1154(a)(1)(B), and

(iv) the physician has collected any amounts for such services,

the physician shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts so collected.

(B) A refund under subparagraph (A) is considered to be on a timely basis only if—

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[531] See Vol. II, P.L. 100-203, §4054(b), with respect to the adjustment in the maximum allowable actual charge in certain cases.

[532] As in original; possibly should be "include".

(i) in the case of a physician who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the physician receives a denial notice under paragraph (2), or

(ii) in the case in which such a reconsideration or appeal is taken, the refund is made within 15 days after the date the physician receives notice of an adverse determination on reconsideration or appeal.

(C) Subparagraph (A) shall not apply to the furnishing of a service by a physician to an individual in the case described in subparagraph (A)(iii)(I) if—

(i) the physician establishes that the physician did not know and could not reasonably have been expected to know that payment may not be made for the service by reason of section 1862(a)(1), or

(ii) before the service was provided, the individual was informed that payment under this part may not be made for the specific service and the individual has agreed to pay for that service.

(2) Each carrier with a contract in effect under this section with respect to physicians and each peer review organization with a contract under part B of title XI shall send any notice of denial of payment for physicians' services based on section 1862(a)(1) and for which payment is not requested on an assignment-related basis to the physician and the individual involved.

(3) If a physician knowingly and willfully fails to make refunds in violation of paragraph (1)(A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(m)(1) In the case of a nonparticipating physician who—

(A) performs an elective surgical procedure for an individual enrolled for benefits under this part and for which the physician's actual charge is at least $500, and

(B) does not accept payment for such procedure on an assignment-related basis,

the physician must disclose to the individual, in writing and in a form approved by the Secretary, the physician's estimated actual charge for the procedure, the estimated approved charge under this part for the procedure, the excess of the physician's actual charge over the approved charge, and the coinsurance amount applicable to the procedure. The written estimate may not be used as the basis for, or evidence in, a civil suit.

(2) A physician who fails to make a disclosure required under paragraph (1) with respect to a procedure shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected for the procedure in excess of the charges recognized and approved under this part.

(3) If a physician knowingly and willfully fails to comply with paragraph (2), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(4) The Secretary shall provide for such monitoring of requests for payment for physicians' services to which paragraph (1) applies as is necessary to assure compliance with paragraph (2).

(n)(1) If a physician's bill or a request for payment for services billed by a physician includes a charge for a diagnostic test described in section 1861(s)(3) (other than a clinical diagnostic laboratory test) for which the bill or request for payment does not indicate that the billing physician personally performed or supervised the performance of the test or that another physician with whom the physician who shares a practice personally performed or supervised the performance of the test, the amount payable with respect to the test shall be determined as follows:

(A) If the bill or request for payment indicates that the test was performed by a supplier, identifies the supplier, and indicates the amount the supplier charged the billing physician, payment for the test (less the applicable deductible and coinsurance amounts) shall be the actual acquisition costs (net of any discounts) or, if lower, the supplier's reasonable charge (or other applicable limit) for the test.

(B) If the bill or request for payment (i) does not indicate who performed the test, or (ii) indicates that the test was performed by a supplier but does not identify the supplier or include the amount charged by the supplier, no payment shall be made under this part.

(2) A physician may not bill an individual enrolled under this part—

(A) any amount other than the payment amount specified in paragraph (1)(A) and any applicable deductible and coinsurance for a diagnostic test for which payment is made pursuant to paragraph (1)(A), or

(B) any amount for a diagnostic test for which payment may not be made pursuant to paragraph (1)(B).

(3) If a physician knowingly and willfully in repeated cases bills one or more individuals in violation of paragraph (2), the Secretary may apply sanctions against such physician in accordance with section 1842(j)(2).

[(o) Repealed.[533]**]**

(p)(1) Each request for payment, or bill submitted, for an item or service furnished by a physician for which payment may be made under this part shall include the appropriate diagnosis code (or codes) as established by the Secretary for such item or service.

(2) In the case of a request for payment for an item or service furnished by a physician on an assignment-related basis which does not include the code (or codes) required under paragraph (1), payment may be denied under this part.

(3) In the case of a request for payment for an item or service furnished by a physician not submitted on an assignment-related basis and which does not include the code (or codes) required under paragraph (1)—

(A) if the physician knowingly and willfully fails to provide the code (or codes) promptly upon request of the Secretary or a carrier, the physician may be subject to a civil money penalty in an amount not to exceed $2,000, and

(B) if the physician knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection, to include the code (or codes) required under paragraph (1), the physician may be subject to the sanction described in section 1842(j)(2)(A).

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[533] P.L. 100-360, §202(c)(1)(C), added subsection (o), applicable to items dispensed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed subsection (o), effective January 1, 1990. **[**For subsection (o) as it formerly read, see Vol. III, P.L. 101-234.**]**

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under subparagraph (A) in the same manner as they apply to a penalty or proceeding under section 1128A(a).[534]

(q)(1)(A)[535] The Secretary, in consultation with groups representing physicians who furnish anesthesia services, shall establish by regulation a relative value guide for use in all carrier localities in making payment for physician anesthesia services furnished under this part. Such guide shall be designed so as to result in expenditures under this title for such services in an amount that would not exceed the amount of such expenditures which would otherwise occur.

(B) For physician anesthesia services furnished under this part during 1991, the prevailing charge conversion factor used in a locality under this subsection shall be determined as follows:

(i) The Secretary shall estimate the national weighted average of the prevailing charge conversion factors used under this subsection for services furnished during 1990 after March 31, using the best available data.

(ii) The national weighted average estimated under clause (i) shall be reduced by 7 percent.

(iii) Subject to clause (iv), the prevailing charge conversion factor to be applied in a locality is the sum of—

(I) the product of (a) the portion of the reduced national weighted average prevailing charge conversion factor computed under clause (ii) which is attributable to physician work and (b) the geographic work index value for the locality (specified in Addendum C to the Model Fee Schedule for Physician Services (published on September 4, 1990, 55 Federal Register pp. 36238-36243)); and

(II) the product of (a) the remaining portion of the reduced national weighted average prevailing charge conversion factor computed under clause (ii) and (b) the geographic practice cost index value specified in section 1842(b)(14)(C)(iv) for the locality.

In applying this clause, 70 percent of the prevailing charge conversion factor shall be considered to be attributable to physician work.

(iv) The prevailing charge conversion factor to be applied to a locality under this subparagraph shall not be reduced by more than 15 percent below the prevailing charge conversion factor applied in the locality for the period during 1990 after March 31, but in no case shall the prevailing charge conversion factor be less than 60 percent of the national weighted average of the prevailing charge conversion factors (computed under clause (i)).[536]

(2) For purposes of payment for anesthesia services (whether furnished by physicians or by certified registered nurse anesthetists)

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[534] P.L. 100-360, §202(g), added subsection (p), applicable to services furnished after March 31, 1989.

[535] P.L. 101-508, §4103(a)(1), redesignated paragraph (1) as subparagraph (A), effective November 5, 1990.

[536] P.L. 101-508, §4103(a)(2), added subparagraph (B), effective November 5, 1990.

under this part, the time units shall be counted based on actual time rather than rounded to full time units.[537]

(r) The Secretary shall establish a system which provides for a unique identifier for each physician who furnishes services for which payment may be made under this title.[538]

STATE AGREEMENTS FOR COVERAGE OF ELIGIBLE INDIVIDUALS WHO ARE RECEIVING MONEY PAYMENTS UNDER PUBLIC ASSISTANCE PROGRAMS (OR ARE ELIGIBLE FOR MEDICAL ASSISTANCE)

Sec. 1843. [42 U.S.C. 1395v] (a) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 or after 1988, enter into an agreement with such State pursuant to which all eligible individuals in either of the coverage groups described in subsection (b) (as specified in the agreement) will be enrolled under the program established by this part.

(b) An agreement entered into with any State pursuant to subsection (a) may be applicable to either of the following coverage groups:

(1) individuals receiving money payments under the plan of such State approved under title I or title XVI; or

(2) individuals receiving money payments under all of the plans of such State approved under titles I, X, XIV, and XVI, and part A of title IV.

Except as provided in subsection (g), there shall be excluded from any coverage group any individual who is entitled to monthly insurance benefits under title II or who is entitled to receive an annuity under the Railroad Retirement Act of 1974[539]. Effective January 1, 1974, and subject to section 1902(f), the Secretary shall, at the request of any State not eligible to participate in the State plan program established under title XVI, continue in effect the agreement entered into under this section with such State subject to such modifications as the Secretary may by regulations provide to take account of the termination of any plans of such State approved under titles I, X, XIV, and XVI and the establishment of the supplemental security income program under title XVI.

(c) For purposes of this section, an individual shall be treated as an eligible individual only if he is an eligible individual (within the meaning of section 1836) on the date an agreement covering him is entered into under subsection (a) or he becomes an eligible individual (within the meaning of such section) at any time after such date; and he shall be treated as receiving money payments described in subsection (b) if he receives such payments for the month in which the agreement is entered into or any month thereafter.

(d) In the case of any individual enrolled pursuant to this section—

(1) the monthly premium to be paid by the State shall be determined under section 1839 (without any increase under subsection (b) thereof);

(2) his coverage period shall begin on whichever of the following is the latest:

(A) July 1, 1966;

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[537] P.L. 101-239, §6106(a), added subsection (q), applicable to services furnished on or after April 1, 1990.

[538] P.L. 101-508, §4118(i)(1), added subsection (r), effective November 5. 1990.

[539] P.L. 75-162 [as amended by P.L. 93-445].

(B) the first day of the third month following the month in which the State agreement is entered into;

(C) the first day of the first month in which he is both an eligible individual and a member of a coverage group specified in the agreement under this section; or

(D) such date as may be specified in the agreement; and

(3) his coverage period attributable to the agreement with the State under this section shall end on the last day of whichever of the following first occurs:

(A) the month in which he is determined by the State agency to have become ineligible both for money payments of a kind specified in the agreement and (if there is in effect a modification entered into under subsection (h)) for medical assistance, or

(B) the month preceding the first month for which he becomes entitled to monthly benefits under title II or to an annuity or pension under the Railroad Retirement Act of 1974.

(e) Any individual whose coverage period attributable to the State agreement is terminated pursuant to subsection (d)(3) shall be deemed for purposes of this part (including the continuation of his coverage period under this part) to have enrolled under section 1837 in the initial general enrollment period provided by section 1837(c). The coverage period under this part of any such individual who (in the last month of his coverage period attributable to the State agreement or in any of the following six months) files notice that he no longer wishes to participate in the insurance program established by this part, shall terminate at the close of the month in which the notice is filed.

(f) With respect to eligible individuals receiving money payments under the plan of a State approved under title I, X, XIV, or XVI, or part A of title IV, or eligible to receive medical assistance under the plan of such State approved under title XIX, if the agreement entered into under this section so provides, the term "carrier" as defined in section 1842(f) also includes the State agency, specified in such agreement, which administers or supervises the administration of the plan of such State approved under title I, XVI, or XIX. The agreement shall also contain such provisions as will facilitate the financial transactions of the State and the carrier with respect to deductions, coinsurance, and otherwise, and as will lead to economy and efficiency of operation, with respect to individuals receiving money payments under plans of the State approved under titles I, X, XIV, and XVI, and part A of title IV, and individuals eligible to receive medical assistance under the plan of the State approved under title XIX.

(g)(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 or after 1988, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the second sentence of subsection (b) shall not apply with respect to such agreement.

(2) In the case of any individual who would (but for this subsection) be excluded from the applicable coverage group described in subsection (b) by the second sentence of such subsection—

(A) subsections (c) and (d)(2) shall be applied as if such subsections referred to the modification under this subsection (in lieu of the agreement under subsection (a)), and

(B) subsection (d)(3)(B) shall not apply so long as there is in effect a modification entered into by the State under this subsection.

(h)(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 or after 1988, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the coverage group described in subsection (b) and specified in such agreement is broadened to include (A) individuals who are eligible to receive medical assistance under the plan of such State approved under title XIX, or (B) qualified medicare beneficiaries (as defined in section 1905(p)(1)).

(2) For purposes of this section, an individual shall be treated as eligible to receive medical assistance under the plan of the State approved under title XIX if, for the month in which the modification is entered into under this subsection or for any month thereafter, he has been determined to be eligible to receive medical assistance under such plan. In the case of any individual who would (but for this subsection) be excluded from the agreement, subsections (c) and (d)(2) shall be applied as if they referred to the modification under this subsection (in lieu of the agreement under subsection (a)), and subsection (d)(2)(C) shall be applied (except in the case of qualified medicare beneficiaries, as defined in section 1905(p)(1)) by substituting "second month following the first month" for "first month".

(3) In this subsection, the term "qualified medicare beneficiary" also includes an individual described in section 1902(a)(10)(E)(iii).[540]

(i) For provisions relating to enrollment of qualified medicare beneficiaries under part A, see section 1818(g).[541]

APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE

SEC. 1844. [42 U.S.C. 1395w] (a) There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund—

(1)(A) a Government contribution equal to the aggregate premiums payable for a month for enrollees age 65 and over under this part and deposited in the Trust Fund, multiplied by the ratio of—

(i) twice the dollar amount of the actuarially adequate rate per enrollee age 65 and over as determined under section 1839(a)(1) for such month minus the dollar amount of the premium per enrollee for such month, as determined under section 1839(a)(3) or 1839(e), as the case may be, to

(ii) the dollar amount of the premium per enrollee for such month, plus

(B) a Government contribution equal to the aggregate premiums payable for a month for enrollees under age 65 under this part and deposited in the Trust Fund, multiplied by the ratio of—

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[540] P.L. 101-508, §4501(d), added paragraph (3), applicable to calendar quarters beginning on or after January 1, 1991, without regard to whether or not regulations to implement this amendment are promulgated by such date.

[541] P.L. 101-239, §6013(b), added subsection (i), effective January 1, 1990.

(i) twice the dollar amount of the actuarially adequate rate per enrollee under age 65 as determined under section 1839(a)(4) for such month minus the dollar amount of the premium per enrollee for such month, as determined under section 1839(a)(3) or 1839(e), as the case may be, to

(ii) the dollar amount of the premium per enrollee for such month; plus

(2) such sums as the Secretary deems necessary to place the Trust Fund, at the end of any fiscal year occurring after June 30, 1967, in the same position in which it would have been at the end of such fiscal year if (A) a Government contribution representing the excess of the premiums deposited in the Trust Fund during the fiscal year ending June 30, 1967, over the Government contribution actually appropriated to the Trust Fund during such fiscal year had been appropriated to it on June 30, 1967, and (B) the Government contribution for premiums deposited in the Trust Fund after June 30, 1967, had been appropriated to it when such premiums were deposited.[542]

(b) In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part, and to provide a contingency reserve, there is also authorized to be appropriated, out of any moneys in the Treasury not otherwise appropriated, to remain available through the calendar year 1969 for repayable advances (without interest) to the Trust Fund, an amount equal to $18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in July 1966 by the insurance program established by this part if they had theretofore enrolled under this part.

PHYSICIAN PAYMENT REVIEW COMMISSION

SEC. 1845. [42 U.S.C. 1395w-1] (a)(1) The Director of the Congressional Office of Technology Assessment (hereinafter in this section referred to as the "Director" and the "Office", respectively) shall provide for the appointment of a Physician Payment Review Commission (hereinafter in this section referred to as the "Commission"), to be composed of individuals with national recognition for their expertise in health economics, physician reimbursement, medical practice, and other related fields appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service).

(2) The Commission shall consist of 13 individuals. Members of the Commission shall first be appointed no later than May 1, 1986, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than four members expire in any one year.[543]

(3) The membership of the Commission shall include (but need not be limited to)[544] physicians, other health professionals, individuals

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[542] P.L. 101-234, §202(a), struck out "In computing the amount of aggregate premiums and premiums per enrollee under paragraph (1), there shall not be taken into account premiums attributable to section 1839(g) or section 59B of the Internal Revenue Code of 1986.", effective January 1, 1990, and applicable to premiums for months beginning after December 31, 1989.

[543] See Vol. II, P.L. 99-509, §9344(a)(2), with respect to the appointment of additional members.

[544] P.L. 101-508, §4118(j)(1)(A), inserted "(but need not be limited to)", effective November 5, 1990.

skilled in the conduct and interpretation of biomedical, health services, and health economics research, and representatives of consumers and the elderly.

(b)(1) The Commission shall make recommendations to the Congress, not later than March 31 of each year (beginning with 1987), regarding adjustments to the reasonable charge levels for physicians' services recognized under section 1842(b) and changes in the methodology for determining the rates of payment, and for making payment, for physicians' services under this title and other items and services under this part.

(2) In making its recommendations, the Commission shall—

(A)[545] assess the likely impact of different adjustments in payment rates, particularly their impact on physician participation in the participation program established under section 1842(h) and on beneficiary access to necessary physicians' services;

(B)[546] make recommendations on ways to increase physician participation in that participation program and the acceptance of payment under this part on an assignment-related basis;

(C)[547] identify those procedures, involving the use of assistants at surgery, for which payment for those assistants should not be made under this title without prior approval;

(D)[548] identify those procedures for which an opinion of a second physician should be required before payment is made under this title;[549]

(E)[550] consider policies for moderating the rate of increase in expenditures under this part and the rate of increase in utilization of services under this part;[551]

(F) make recommendations regarding major issues in the implementation of the resource-based relative value scale established under section 1848(c);[552]

(G) make recommendations regarding further development of the volume performance standards established under section 1848(f), including the development of State-based programs;[553]

(H) consider policies to provide payment incentives to increase patient access to primary care and other physician services in large urban and rural areas, including policies regarding payments to physicians pursuant to title XIX;[554]

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[545] P.L. 101-508, §4118(j)(1)(C)(iii), struck out the former subparagraph (A) and §4118(j)(1)(C)(iv) redesignated the former subparagraph (D) as subparagraph (A), effective November 5, 1990. [For subparagraph (A) as it formerly read, see Vol. III, P.L. 101-508.]

[546] P.L. 101-508, §4118(j)(1)(C)(iii), struck out the former subparagraph (B) and §4118(j)(1)(C)(iv) redesignated the former subparagraph (E) as subparagraph (B), effective November 5, 1990. [For subparagraph (B) as it formerly read, see Vol. III, P.L. 101-508.]

[547] P.L. 101-508, §4118(j)(1)(C)(iii), struck out the former subparagraph (C) and §4118(j)(1)(C)(iv) redesignated the former subparagraph (G) as subparagraph (C), effective November 5, 1990. [For subparagraph (C) as it formerly read, see Vol. III, P.L. 101-508.]

[548] P.L. 101-508, §4118(j)(1)(C)(iv) redesignated the former subparagraph (H) as subparagraph (D), effective November 5, 1990.

[549] P.L. 101-508, §4118(j)(1)(C)(i), struck out "and".

[550] P.L. 101-508, §4118(j)(1)(C)(iv) redesignated the former subparagraph (I) as subparagraph (E), effective November 5, 1990.

[551] P.L. 101-508, §4118(j)(1)(C)(ii), struck out a period and substituted a semicolon.

[552] P.L. 101-508, §4118(j)(1)(C)(iii), struck out the former subparagraph (F) and §4118(j)(1)(C)(v) inserted this subparagraph (F), effective November 5, 1990. [For subparagraph (F) as it formerly read, see Vol. III, P.L. 101-508.]

[553] P.L. 101-508, §4118(j)(1)(C)(v), added this subparagraph (G), effective November 5, 1990.

[554] P.L. 101-508, §4118(j)(1)(C)(v), added this subparagraph (H), effective November 5, 1990.

(I) review and consider the number and practice specialties of physicians in training and payments under this title for graduate medical education costs;[555]

(J) make recommendations regarding issues relating to utilization review and quality of care, including the effectiveness of peer review procedures and other quality assurance programs applicable to physicians and providers under this title and physician certification and licensing standards and procedures;[556]

(K) make recommendations regarding options to help constrain the costs of health insurance to employers, including incentives under this title;[557]

(L) comment on the recommendations affecting physician payment under the medicare program that are included in the budget submitted by the President pursuant to section 1105 of title 31, United States Code; and[558]

(M) make recommendations regarding medical malpractice liability reform and physician certification and licensing standards and procedures.[559]

[(3) Stricken.[560]]

(c)(1) The following provisions of section 1886(e)(6) shall apply to the Commission in the same manner as they apply to the Prospective Payment Assessment Commission:

(A) Subparagraph (C) (relating to staffing and administration generally).

(B) Subparagraph (D) (relating to compensation of members).

(C) Subparagraph (F) (relating to access to information).

(D) Subparagraph (G) (relating to [561] use of funds).

(E) Subparagraph (H) (relating to periodic GAO audits).

(F) Subparagraph (J) (relating to requests for appropriations).

(2) In order to carry out its functions, the Commission shall collect and assess information on medical and surgical procedures and services, including information on regional variations of medical practice. In collecting and assessing information, the Commission shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate for the development of useful and valid guidelines by the Commission, and

(C) adopt procedures allowing any interested party to submit information with respect to physicians' services (including new practices, such as the use of new technologies and treatment modalities), which information the Commission shall consider in making reports and recommendations to the Secretary and Congress.

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[555] P.L. 101-508, §4118(j)(1)(C)(v), added this subparagraph (I), effective November 5, 1990.

[556] P.L. 101-508, §4118(j)(1)(C)(v), added subparagraph (J), effective November 5, 1990.

[557] P.L. 101-508, §4118(j)(1)(C)(v), added subparagraph (K), effective November 5, 1990.

[558] P.L. 101-508, §4118(j)(1)(C)(v), added subparagraph (L), effective November 5, 1990.

[559] P.L. 101-508, §4118(j)(1)(C)(v), added subparagraph (M), effective November 5, 1990.

[560] P.L. 101-508, §4118(j)(1)(B), struck out the former paragraph (3), effective November 5, 1990. [For paragraph (3) as it formerly read, see Vol. III, P.L. 101-508.]

[561] P.L. 101-508, §4002(g)(3), struck out "reports and", effective November 5, 1990.

(d) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

(e)[562](1) Not later than December 31st of each year (beginning with 1988), the Secretary shall transmit to the Physician Payment Review Commission, to the Congressional Budget Office, and to the Congressional Research Service of the Library of Congress national data (known as the Part B Medicare Annual Data System) for the previous year respecting part B of this title.

(2) In order to ensure that the data are available for transmittal under paragraph (1) on a timely basis, the Secretary shall require, in the standards and criteria established under section 1842(b)(2), that carriers submit data for a year under the system referred to in paragraph (1) not later than the later of (A) July 1st of the following year, or (B) 45 days after the date of a reasonable charge update.

(3) The Secretary, in consultation with the Physician Payment Review Commission, the Congressional Budget Office, and the Congressional Research Service of the Library of Congress, shall establish and annually revise standards for the data reporting system described in paragraph (1).

(4) The Secretary shall also provide to the entities described in paragraph (1) additional data respecting the program under this part as may be reasonably requested by them on an agreed-upon schedule.

(5) The Secretary shall develop, in consultation with the Physician Payment Review Commission, the Congressional Budget Office, and the Congressional Research Service of the Library of Congress, a system for providing to each of such entities on a quarterly basis summary data on aggregate expenditures under this part by type of service and by type of provider. Such data shall be provided not later than 90 days after the end of each quarter (for quarters beginning with the calendar quarter ending on March 31, 1989).

INTERMEDIATE SANCTIONS FOR PROVIDERS OR SUPPLIERS[563] OF CLINICAL DIAGNOSTIC LABORATORY TESTS[564]

SEC. 1846. [42 U.S.C. 1395w-2] (a) If the Secretary determines that any provider or clinical laboratory approved[565] for participation under this title no longer substantially meets the conditions of participation or for coverage[566] specified under this title with respect to the provision of clinical diagnostic laboratory tests under this part[567], the Secretary may (for a period not to exceed one year) impose intermediate sanctions developed pursuant to subsection (b), in lieu of terminating immediately the provider agreement or cancelling immediately approval of the clinical laboratory[568].

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[562] P.L. 101-508, §4118(j)(1)(D), struck out the former subsection (e) and redesignated subsection (f) as subsection (e), effective November 5, 1990. [For subsection (e) as it formerly read, see Vol. III, P.L. 101-508.]

[563] P.L. 101-508, §4154(e)(2), inserted "OR SUPPLIERS", effective as if included in the enactment of P.L. 101-239.

[564] P.L. 100-203, §4064(d)(1), added §1846, effective January 1, 1990.

P.L. 100-360, §203(e)(4)(A), added "AND FOR QUALIFIED HOME INTRAVENOUS DRUG THERAPY PROVIDERS", applicable to items and services furnished on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "AND FOR QUALIFIED HOME INTRAVENOUS DRUG THERAPY PROVIDERS", effective January 1, 1990.

[565] P.L. 100-360, §411(g)(3)(G)(i)(I), struck out "certified" and substituted "approved", effective as if included in the enactment of P.L. 100-203.

[566] P.L. 100-360, §411(g)(3)(G)(i)(II), inserted "or for coverage", effective as if included in the enactment of P.L. 100-203.

[567] P.L. 100-360, §203(e)(4)(B), inserted "or that a qualified home intravenous drug therapy provider that is certified for participation under this title no longer substantially meets the requirements of section 1861(jj)(3)", applicable to items and services furnished on or after January

(b)(1) The Secretary shall develop and implement—

(A) a range of intermediate sanctions to apply to providers or[569] clinical laboratories under the conditions described in subsection (a), and

(B) appropriate procedures for appealing determinations relating to the imposition of such sanctions.

(2)(A) The intermediate sanctions developed under paragraph (1) shall include—

(i) directed plans of correction,

(ii) civil money penalties in an amount not to exceed $10,000 for each day of substantial noncompliance,[570]

(iii) payment for the costs of onsite monitoring by an agency responsible for conducting[571] surveys, and

(iv) suspension of all or part of the payments to which a provider or[572] clinical laboratory would otherwise be entitled under this title with respect to clinical diagnostic laboratory tests[573] furnished on or after the date on[574] which the Secretary determines that intermediate sanctions should be imposed pursuant to subsection (a).

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (ii) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).[575]

(B) The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law.

(3) The Secretary shall develop and implement specific procedures with respect to when and how each of the intermediate sanctions developed under paragraph (1) is to be applied, the amounts of any penalties[576], and the severity of each of these penalties. Such proce-

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1, 1990.

P.L. 101-234, §201(a)(1), repealed that amendment, effective January 1, 1990.

[568] P.L. 100-360, §411(g)(3)(G)(i)(III), struck out "cancelling[*] immediately the certification[**] of the provider or clinical laboratory" and substituted "terminating immediately the provider agreement or cancelling immediately approval of the clinical laboratory", effective as if included in the enactment of P.L. 100-203.

[*] Read "canceling" in P.L. 100-203, §4064(d)(1).

[**] P.L. 100-360, §411(g)(3)(G)(i)(I), struck out "certification" and substituted "approval", effective as if included in the enactment of P.L. 100-203.

P.L. 100-360, §411(g)(3)(G)(i)(I) [as amended by P.L. 100-485, §608(d)(22)(C)], in effect, struck out "approval" and restored "certification", effective as if §608(d)(22)(C) were included in the enactment of P.L. 100-360.

[569] P.L. 100-360, §411(g)(3)(G)(ii), struck out "certified", effective as if included in the enactment of P.L. 100-203.

[570] P.L. 100-360, §411(g)(3)(G)(iii), amended clause (ii) in its entirety, effective as if included in the enactment of P.L. 100-203. [For clause (ii) as it formerly read, see Vol. III, P.L. 100-360.]

[571] P.L. 100-360, §411(g)(3)(G)(v), struck out "certification", effective as if included in the enactment of P.L. 100-203.

[572] P.L. 100-360, §411(g)(3)(G)(ii), struck out "certified", effective as if included in the enactment of P.L. 100-203.

[573] P.L. 100-360, §203(e)(4)(C), inserted "or home intravenous drug therapy services", applicable to items and services furnished on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "or home intravenous drug therapy services", effective January 1, 1990.

[574] P.L. 100-360, §411(g)(3)(G)(vi), struck out "provided on or after the date in" and substituted "furnished on or after the date on", effective as if included in the enactment of P.L. 100-203.

[575] P.L. 100-360, §411(g)(3)(G)(iv), added this sentence, effective as if included in the enactment of P.L. 100-203.

[576] P.L. 100-360, §411(g)(3)(G)(vii), struck out "fines" and substituted "penalties", effective as if included in the enactment of P.L. 100-203.

dures shall be designed so as to minimize the time between identification of violations and imposition of these sanctions and shall provide for the imposition of incrementally more severe penalties[577] for repeated or uncorrected deficiencies.

[SEC. 1847. Repealed.[578]]

PAYMENT FOR PHYSICIANS' SERVICES[579]

SEC. 1848. [42 U.S.C. 1395w-4] (a) PAYMENT BASED ON FEE SCHEDULE.—

(1) IN GENERAL.—Effective for all physicians' services (as defined in subsection (j)(3)) furnished under this part during a year (beginning with 1992) for which payment is otherwise made on the basis of a reasonable charge or on the basis of a fee schedule under section 1834(b)[580], payment under this part shall instead be based on the lesser of—

(A) the actual charge for the service, or

(B) subject to the succeeding provisions of this subsection, the amount determined under the fee schedule established under subsection (b) for services furnished during that year (in this subsection referred to as the "fee schedule amount").

(2) TRANSITION TO FULL FEE SCHEDULE.—

(A) LIMITING REDUCTIONS AND INCREASES TO 15 PERCENT IN 1992.—

(i) LIMIT ON INCREASE.—In the case of a service in a fee schedule area (as defined in subsection (j)(2)) for which the adjusted historical payment basis (as defined in subparagraph (D)) is less than 85 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis plus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

(ii) LIMIT IN REDUCTION.—In the case of a service in a fee schedule area for which the adjusted historical payment basis exceeds 115 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis minus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

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[577] P.L. 100-360, §411(g)(3)(G)(vii), struck out "fines" and substituted "penalties", effective as if included in the enactment of P.L. 100-203.

[578] P.L. 100-360, §202(j) added §1847, applicable to items dispensed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed §1847, effective January 1, 1990. [For §1847 as it formerly read, see Vol. III, P.L. 101-234.]

P.L. 100-360, §202(m)(5), with respect to transition expenses and costs, was repealed by P.L. 101-234, §201(a)(1), effective January 1, 1990.

[579] P.L. 101-239, §6102(a), added §1848, effective December 19, 1989.

P.L. 101-239, §6102(e)(11), requires that (1) by September 1, 1990, the Secretary develop a Model Fee Schedule, using the methodology set forth in §1848; (2) the Model Fee Schedule include as many services as the Secretary concludes can be assigned valid relative value; and (3) the Secretary submit the Model Fee Schedule to the appropriate committees of Congress and make it generally available to the public.

See Vol. II, P.L. 101-239, §6102(d), with respect to studies required.

See Vol. II, P.L. 101-508, §4115, with respect to a study of regional variations in impact of Medicare physician payment reform.

[580] P.L. 101-508, §4104(b)(2), struck out "or 1834(f)", applicable to services furnished on or after January 1, 1991.

(B) SPECIAL RULE FOR 1993, 1994, AND 1995.—If a physicians' service in a fee schedule area is subject to the provisions of subparagraph (A) in 1992, for physicians' services furnished in the area—

(i) during 1993, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 75 percent of the fee schedule amount determined under subparagraph (A), adjusted by the update established under subsection (d)(3) for 1993, and

(II) 25 percent of the fee schedule amount determined under paragraph (1) for 1993 without regard to this paragraph;

(ii) during 1994, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 67 percent of the fee schedule amount determined under clause (i), adjusted by the update established under subsection (d)(3) for 1994, and

(II) 33 percent of the fee schedule amount determined under paragraph (1) for 1994 without regard to this paragraph; and

(iii) during 1995, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 50 percent of the fee schedule amount determined under clause (ii) adjusted by the update established under subsection (d)(3) for 1995, and

(II) 50 percent of the fee schedule amount determined under paragraph (1) for 1995 without regard to this paragraph.

(C) SPECIAL RULE FOR ANESTHESIA AND RADIOLOGY[581] SERVICES.—With respect to physicians' services which are anesthesia services, the Secretary shall provide for a transition in the same manner as a transition is provided for other services under subparagraph (B). With respect to radiology services, "109 percent" and "9 percent" shall be substituted for "115 percent" and "15 percent", respectively, in subparagraph (A)(ii).[582]

(D) ADJUSTED HISTORICAL PAYMENT BASIS DEFINED.—

(i) IN GENERAL.—In this paragraph, the term "adjusted historical payment basis" means, with respect to a physicians' service furnished in a fee schedule area, the weighted average prevailing charge applied in the area for the service in 1991 (as determined by the Secretary without regard to physician specialty and as adjusted to reflect payments for services with customary charges below the prevailing charge or other payment limitations imposed by law or regulation) adjusted by the update established under subsection (d)(3) for 1992.

(ii) APPLICATION TO RADIOLOGY SERVICES.—In applying clause (i) in the case of physicians' services which are radiology services (including radiologist services, as defined in section 1834(b)(6)), but excluding nuclear medicine services that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989[583], there shall be substituted for the weighted average prevailing charge the amount provided under the fee schedule established for the service for the fee schedule area under section 1834(b).

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[581] P.L. 101-508, §4102(b)(1), inserted "AND RADIOLOGY", applicable to services furnished on or after January 1, 1991.

[582] P.L. 101-508, §4102(b)(2), added this sentence, applicable to services furnished on or after January 1, 1991.

(iii) NUCLEAR MEDICINE SERVICES.—In applying clause (i) in the case of physicians' services which are nuclear medicine services that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989[584], there shall be substituted for the weighted average prevailing charge the amount provided under such section.[585]

(3) INCENTIVES FOR PARTICIPATING PHYSICIANS.—In applying paragraph (1)(B) in the case of a nonparticipating physician, the fee schedule amount shall be 95 percent of such amount otherwise applied under this subsection (without regard to this paragraph).

(4) TREATMENT OF NEW PHYSICIANS.—In the case of physicians' services furnished by a physician before the end of the physician's first full calendar year of furnishing services for which payment may be made under this part, and during each of the 3 succeeding years, the fee schedule amount to be applied shall be 80 percent, 85 percent, 90 percent, and 95 percent, respectively, of the fee schedule amount applicable to physicians who are not subject to this paragraph. The preceding sentence shall not apply to primary care services or services furnished in a rural area (as defined in section 1886(d)(2)) that is designated under section 322(a)(1)(A) of the Public Health Service Act[586] as a health manpower[587] shortage area.[588]

(b) ESTABLISHMENT OF FEE SCHEDULES.—

(1) IN GENERAL.—Before January 1 of each year beginning with 1992, the Secretary shall establish, by regulation, fee schedules that establish payment amounts for all physicians' services furnished in all fee schedule areas (as defined in subsection (j)(2)) for the year. Except as provided in paragraph (2), each such payment amount for a service shall be equal to the product of—

(A) the relative value for the service (as determined in subsection (c)(2)),

(B) the conversion factor (established under subsection (d)) for the year, and

(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area.

(2) TREATMENT OF RADIOLOGY SERVICES AND ANESTHESIA SERVICES.—

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[583] P.L. 101-508, §4102(g)(2)(A), inserted ", but excluding nuclear medicine services that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989", applicable to services furnished on or after January 1, 1991.

[584] P.L. 101-239.

[585] P.L. 101-508, §4102(g)(2)(B), added clause (iii), applicable to services furnished on or after January 1, 1991.

[586] P.L. 78-410.

[587] Probably should be "professional".

[588] P.L. 101-508, §4106(b)(1), added paragraph (4), applicable to services furnished after 1991.

(A) RADIOLOGY SERVICES.—With respect to radiology services (including radiologist services, as defined in section 1834(b)(6)), the Secretary shall base the relative values on the relative value scale developed under section 1834(b)(1)(A), with appropriate modifications of the relative values to assure that the relative values established for radiology services which are similar or related to other physicians' services are consistent with the relative values established for those similar or related services.

(B) ANESTHESIA SERVICES.—In establishing the fee schedule for anesthesia services for which a relative value guide has been established under section 4048(b) of the Omnibus Budget Reconciliation Act of 1987[589], the Secretary shall use, to the extent practicable, such relative value guide, with appropriate adjustment of the conversion factor, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value. In applying the previous sentence, the Secretary shall adjust the conversion factor by geographic adjustment factors in the same manner as such adjustment is made under paragraph (1)(C).

(C) CONSULTATION.—The Secretary shall consult with the Physician Payment Review Commission and organizations representing physicians or suppliers who furnish radiology services and anesthesia services in applying subparagraphs (A) and (B).

(3) TREATMENT OF INTERPRETATION OF ELECTROCARDIOGRAMS.—If payment is made under this part for a visit to a physician or consultation with a physician and, as part of or in conjunction with the visit or consultation there is an electrocardiogram performed or ordered to be performed, no payment may be made under this part with respect to the interpretation of the electrocardiogram and no physician may bill an individual enrolled under this part separately for such an interpretation. If a physician knowingly and willfully bills one or more individuals in violation of the previous sentence, the Secretary may apply sanctions against the physician \or entity in accordance with section 1842(j)(2).[590]

(c) DETERMINATION OF RELATIVE VALUES FOR PHYSICIANS' SERVICES.—

(1) DIVISION OF PHYSICIANS' SERVICES INTO COMPONENTS.—In this section, with respect to a physicians' service:

(A) WORK COMPONENT DEFINED.—The term "work component" means the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service. Such portion shall—

(i) include activities before and after direct patient contact, and

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[589] P.L. 100-203.

[590] P.L. 101-508, §4109(a), added paragraph (3), applicable to services furnished on or after January 1, 1992. In applying §1848(d)(1)(B) (in computing the initial budget-neutral conversion factor for 1991), the Secretary shall compute such factor assuming that §1848(b)(3) had applied to physicians' services furnished during 1991.

(ii) be defined, with respect to surgical procedures, to reflect a global definition including pre-operative and post-operative physicians' services.

(B) PRACTICE EXPENSE COMPONENT DEFINED.—The term "practice expense component" means the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising practice expenses.[591]

(C) MALPRACTICE COMPONENT DEFINED.—The term "malpractice component" means the portion of the resources used in furnishing the service that reflects malpractice expenses in furnishing the service.

(2) DETERMINATION OF RELATIVE VALUES.—

(A) IN GENERAL.—

(i) COMBINATION OF UNITS FOR COMPONENTS.—The Secretary shall develop a methodology for combining the work, practice expense, and malpractice relative value units, determined under subparagraph (C), for each service in a manner to produce a single relative value for that service.

(ii) EXTRAPOLATION.—The Secretary may use extrapolation and other techniques to determine the number of relative value units for physicians' services for which specific data are not available and shall take into account recommendations of the Physician Payment Review Commission and the results of consultations with organizations representing physicians who provide such services.

(B) PERIODIC REVIEW AND ADJUSTMENTS IN RELATIVE VALUES.—

(i) PERIODIC REVIEW.—The Secretary, not less often than every 5 years, shall review the relative values established under this paragraph for all physicians' services.

(ii) ADJUSTMENTS.—

(I) IN GENERAL.—The Secretary shall, to the extent the Secretary determines to be necessary and subject to subclause (II), adjust the number of such units to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary shall publish an explanation of the basis for such adjustments.

(II) LIMITATION ON ANNUAL ADJUSTMENTS.—The adjustments under subclause (I) for a year may not cause the amount of expenditures under this part for the year to differ by more than $20,000,000 from the amount of expenditures under this part that would have been made if such adjustments had not been made.

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[591] P.L. 101-508, §4118(f)(1)(A), struck out "In this subparagraph, the term 'practice expenses' includes all expenses for furnishing physicians' services, excluding malpractice expenses, physician compensation, and other physician fringe benefits.", effective November 5, 1990.

(iii) CONSULTATION.—The Secretary, in making adjustments under clause (ii), shall consult with the Physician Payment Review Commission and organizations representing physicians.

(C) COMPUTATION OF RELATIVE VALUE UNITS FOR COMPONENTS.—For purposes of this section for each physicians' service—

(i) WORK RELATIVE VALUE UNITS.—The Secretary shall determine a number of work relative value units for the service based on the relative resources incorporating physician time and intensity required in furnishing the service.

(ii) PRACTICE EXPENSE RELATIVE VALUE UNITS.—The Secretary shall determine a number of practice expense relative value units equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service, and

(II) the practice expense percentage for the service (as determined under paragraph (3)(C)(ii)).

(iii) MALPRACTICE RELATIVE VALUE UNITS.—The Secretary shall determine a number of malpractice relative value units equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service, and

(II) the malpractice percentage for the service (as determined under paragraph (3)(C)(iii)).

(D) BASE ALLOWED CHARGES DEFINED.—In this paragraph, the term "base allowed charges" means, with respect to a physician's service, the national average allowed charges for the service under this part for services furnished during 1991, as estimated by the Secretary using the most recent data available.

(3) COMPONENT PERCENTAGES.—For purposes of paragraph (2), the Secretary shall determine a work percentage, a practice expense percentage, and a malpractice percentage for each physician's service as follows:

(A) DIVISION OF SERVICES BY SPECIALTY.—For each physician's service or class of physicians' services, the Secretary shall determine the average percentage of each such service or class of services that is performed, nationwide, under this part by physicians in each of the different physician specialties (as identified by the Secretary).

(B) DIVISION OF SPECIALTY BY COMPONENT.—The Secretary shall determine the average percentage division of resources, among the work component, the practice expense component, and the malpractice component, used by physicians in each of such specialties in furnishing physicians' services. Such percentages shall be based on national data that describe the elements of physician practice costs and revenues, by physician specialty. The Secretary may use extrapolation and other techniques to determine practice costs and revenues for specialties for which adequate data are not available.

(C) DETERMINATION OF COMPONENT PERCENTAGES.—

(i) Work percentage.—The work percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the work component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(ii) Practice expense percentage.—The practice expense percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the practice expense component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) [592] the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(iii) Malpractice percentage.—The malpractice percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the malpractice component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) [593] the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(D) Periodic recomputation.—The Secretary may, from time to time, provide for the recomputation of work percentages, practice expense percentages, and malpractice percentages determined under this paragraph.[594]

(4)[595] Ancillary policies.—The Secretary may establish ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement this section[596].

(5)[597] Coding.—The Secretary shall establish a uniform procedure coding system for the coding of all physicians' services. The Secretary shall provide for an appropriate coding structure for visits and consultations. The Secretary may incorporate the use of time in the coding for visits and consultations[598]. The Secretary, in establishing such coding system, shall consult with the Physician Payment Review Commission and other organizations representing physicians.

(6)[599] No variation for specialists.—The Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.

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[592] P.L. 101-508, §4118(f)(1)(B), struck out "by", effective November 5, 1990.

[593] P.L. 101-508, §4118(f)(1)(B), struck out "by", effective November 5, 1990.

[594] See Vol. II, P.L. 101-508, §4104(c), with respect to physician pathology services.

[595] P.L. 101-508, §4118(f)(1)(C), redesignated paragraph (3) as paragraph (4), effective November 5, 1990.

[596] P.L. 101-508, §4118(f)(1)(D), struck out "subsection" and substituted "section", effective November 5, 1991.

[597] P.L. 101-508, §4118(f)(1)(C), redesignated paragraph (4) as paragraph (5), effective November 5, 1990.

[598] P.L. 101-508, §4118(d), struck out "only for services furnished on or after January 1, 1993", effective November 5, 1990.

[599] P.L. 101-508, §4118(f)(1)(C), redesignated paragraph (5) as paragraph (6), effective November 5, 1990.

(d) CONVERSION FACTORS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The conversion factor (or factors)[600] for each year shall be the conversion factor (or factors)[601] established under this subsection for the previous year (or, in the case of 1992, specified in subparagraph (B)) adjusted by the update or updates[602] (established under paragraph (3)[603]) for the year involved.

(B) SPECIAL PROVISION FOR 1992.—For purposes of subparagraph (A), the conversion factor specified in this subparagraph is a conversion factor (determined by the Secretary) which, if this section were to apply during 1991 using such conversion factor, would result in the same aggregate amount of payments under this part for physicians' services as the estimated aggregate amount of the payments under this part for such services in 1991.[604]

(C) PUBLICATION.—The Secretary shall cause to have published in the Federal Register, during the last 15 days of October of—

(i) 1991, the conversion factor[605] which will apply to physicians' services for 1992, and the update (or updates) determined under paragraph (3) for 1992; and

(ii) each succeeding year, the conversion factor (or factors) which will apply to physicians' services for the following year and[606] the update (or updates) determined under paragraph (3) for such[607] year.

(2) RECOMMENDATION OF UPDATE.—

(A) IN GENERAL.—Not later than April 15 of each year (beginning with 1991), the Secretary shall transmit to the Congress a report that includes a recommendation on the appropriate update (or updates) in the conversion factor (or factors) for all physicians' services (as defined in subsection (f)(5)(A))[608] in the following year. The Secretary may recommend a uniform update or different updates for different categories or groups of services. In making the recommendation, the Secretary shall consider—

(i) the percentage change in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for that year;

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[600] P.L. 101-508, §4118(f)(1)(F)(i)(I), inserted "(or factors)", effective November 5, 1990.

[601] P.L. 101-508, §4118(f)(1)(F)(i)(I), inserted "(or factors)", effective November 5, 1990.

[602] P.L. 101-508, §4118(f)(1)(F)(i)(II), inserted "or updates", effective November 5, 1990.

[603] P.L. 101-508, §4118(f)(1)(E), struck out "subparagraph (C)" and substituted "paragraph (3)", effective November 5, 1990.

P.L. 101-508, §4118(f)(1)(F)(i)(III), made the same amendment.

[604] See Vol. II, P.L. 101-508, §4105(b)(2) and §4106(c), with respect to conversion factor computation.

[605] P.L. 101-508, §4118(f)(1)(F)(ii)(I), struck out "(or factors)", effective November 5, 1990.

[606] P.L. 101-508, §4118(f)(1)(F)(ii)(II), inserted "the conversion factor (or factors) which will apply to physicians' services for the following year and", effective November 5, 1990.

[607] P.L. 101-508, §4118(f)(1)(F)(ii)(II), struck out "the following" and substituted "such", effective November 5, 1990.

[608] P.L. 101-508, §4118(f)(1)(G), inserted "(as defined in subsection (f)(5)(A))", effective November 5, 1990.

(ii) the percentage by which actual expenditures for all physicians' services and for the services involved[609] under this part for the fiscal year ending in the year preceding the year in which such recommendation is made were greater or less than actual expenditures for such[610] services in the fiscal year ending in the second preceding year;

(iii) the relationship between the percentage determined under clause (ii) for a fiscal year and the performance standard rate of increase (established under subsection (f)(2)) for that fiscal year;

(iv) changes in volume or intensity of services;

(v) access to services; and

(vi) other factors that may contribute to changes in volume or intensity of services or access to services.

For purposes of making the comparison under clause (iii), the Secretary shall adjust the performance standard rate of increase for a fiscal year to reflect changes in the actual proportion of individuals who are enrolled under this part who are[611] HMO enrollees (as defined in subsection (f)(5)(B)) in that fiscal year compared with such proportion for the previous fiscal year.

(B) Additional considerations.—In making recommendations under subparagraph (A), the Secretary may also consider—

(i) unexpected changes by physicians in response to the implementation of the fee schedule;

(ii) unexpected changes in outlay projections;

(iii) changes in the quality or appropriateness of care; and

(iv) any other relevant factors not measured in the resource-based payment methodology.

(C) Special rule for 1992 Update.—In considering the update for 1992, the Secretary shall make a separate determination of the percentage and relationship described in clauses (ii) and (iii) of subparagraph (A) with respect to the category of surgical services (as defined by the Secretary pursuant to subsection (j)(1)).

(D) Explanation of update.—The Secretary shall include in each report under subparagraph (A)—

(i) the update recommended for each category of physicians' services (established by the Secretary under subsection (j)(1)) and for each of the following groups of physicians' services: nonsurgical services, visits, consultations, and emergency room services;

(ii) the rationale for the recommended update (or updates) for each category and group of services described in clause (i); and

(iii) the data and analyses underlying the update (or updates) recommended.

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[609] P.L. 101-508, §4118(f)(1)(H)(i), struck out "(as defined in subsection (f)(5)(A))" and substituted "and for the services involved", effective November 5, 1990.

[610] P.L. 101-508, §4118(f)(1)(H)(ii), struck out "all such physicians' " and substituted "such", effective November 5, 1990.

[611] P.L. 101-508, §4118(f)(1)(I), inserted "individuals who are enrolled under this part who are", effective November 5, 1990.

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection.[662] For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), section 1814(f)(2), and subsection (i) of this section[663], such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r), to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2),[664] include any institution which is primarily for the care and treatment of mental diseases unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—

(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall provide for temporary waiver of the requirements, for such period as the Secretary deems appropriate, where (i) the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area in which the facility is located, (ii) a registered professional nurse is present on the premises to render or supervise the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients;

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[662] P.L. 101-234, §101(a)(1), inserted "For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection.", effective January 1, 1990. For the applicability of this amendment, see Vol. II, P.L. 100-360, §104(a).

[663] P.L. 101-234, §101(a)(1), struck out "and section 1814(f)(2)" and substituted "section 1814(f)(2), and subsection (i) of this section", effective January 1, 1990. For the applicability of this amendment, see Vol. II, P.L. 100-360, §104(a).

[664] P.L. 101-234, §101(a)(1), inserted ", except for purposes of subsection (a)(2),", effective January 1, 1990. For the applicability of this amendment, see Vol. II, P.L. 100-360, §104(a).

(B) with respect to the health and safety requirements promulgated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such manner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facility is located, and the scope of services rendered by such facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such personnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the personnel requirements, (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the health and safety of patients, and (iii) if the Secretary has determined that because of the facility's waiver under this subparagraph the facility should limit its scope of services in order not to adversely affect the health and safety of the facility's patients, the facility is so limiting the scope of services it provides; and

(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary (i) may waive, for such period as he deems appropriate, specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for such a facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.

The term "hospital" does not include, unless the context otherwise requires, a rural primary care hospital (as defined in section 1861(mm)(1)).[665]

Psychiatric Hospital

(f) The term "psychiatric hospital" means an institution which—

(1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);

(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under part A; and

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[665] P.L. 101-239, §6003(g)(3)(D)(x)(I), added this sentence, effective December 19, 1989.

(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a "psychiatric hospital".

Outpatient Occupational Therapy Services

(g) The term "outpatient occupational therapy services" has the meaning given the term "outpatient physical therapy services" in subsection (p), except that "occupational" shall be substituted for "physical" each place it appears therein.

Extended Care Services

(h) The term "extended care services" means the following items and services furnished to an inpatient of a skilled nursing facility and (except as provided in paragraphs (3) and (6)) by such skilled nursing facility—

(1) nursing care provided by or under the supervision of a registered professional nurse;

(2) bed and board in connection with the furnishing of such nursing care;

(3) physical, occupational, or speech therapy furnished by the skilled nursing facility or by others under arrangements with them made by the facility;

(4) medical social services;

(5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility, as are ordinarily furnished by such facility for the care and treatment of inpatients;

(6) medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of subsection (l)), under a teaching program of such hospital approved as provided in the last sentence of subsection (b), and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and

(7) such other services necessary to the health of the patients as are generally provided by skilled nursing facilities;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

Post-Hospital Extended Care Services[666]

(i) The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility (A) within 30 days after discharge from such hospital, or (B) within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 30 days after discharge from a hospital; and an individual shall be deemed not to have been discharged from a skilled nursing facility if, within 30 days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.

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[666] P.L. 101-234, §101(a)(1), added subsection (i), effective January 1, 1990. For the applicability of this amendment, see Vol. II, P.L. 100-360, §104(a).

Skilled Nursing Facility[667]

(j) The term "skilled nursing facility" has the meaning given such term in section 1819(a).

Utilization Review

(k) A utilization review plan of a hospital or skilled nursing facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this title and if it provides—

(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

(2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians (of which at least two must be physicians described in subsection (r)(1) of this section), with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after opportu-

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[667] P.L. 100-203, §4201(a)(1), amended subsection (j) in its entirety. For the effective date, see Vol. II, P.L. 100-203, §4204(a). [For subsection (j) as it formerly read, see Vol. III, P.L. 100-203.]

Effective July 1, 1988, and until the effective date of §1819(c), §1861(j) is deemed to include the requirement described in §1819(c)(3)(A) (as added by §4201(a)(3) of the Omnibus Budget Reconciliation Act of 1987).

nity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or skilled nursing facility where, because of the small size of the institution, or (in the case of a skilled nursing facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection. If the Secretary determines that the utilization review procedures established pursuant to title XIX are superior in their effectiveness to the procedures required under this section, he may, to the extent that he deems it appropriate, require for purposes of this title that the procedures established pursuant to title XIX be utilized instead of the procedures required by this section.

Agreements for Transfer Between Skilled Nursing Facilities and Hospitals

(l) A hospital and a skilled nursing facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

(1) transfer of patients will be effected between the hospital and the skilled nursing facility whenever such transfer is medically appropriate as determined by the attending physician; and

(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any skilled nursing facility which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under section 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this title.

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical, occupational, or speech therapy;

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary;

(5) medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care, but excluding drugs and biologicals) and durable medical equipment while under such a plan;[668]

(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A),

but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.[669]

Durable Medical Equipment

(n) The term "durable medical equipment" includes iron lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe) used in the patient's home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) of this section or section 1819(a)(1)), whether furnished on a rental basis or purchased; except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment[670]. With respect to a seat-lift chair, such term includes only the seat-lift mechanism and does not include the chair.[671]

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[668] P.L. 101-239, §6112(e)(1), amended paragraph (5) in its entirety, applicable with respect to items furnished on or after January 1, 1990. [For paragraph (5) as it formerly read, see Vol. III, P.L. 101-239.]

[669] P.L. 100-360, §206(a), added "For purposes of paragraphs (1) and (4) and sections 1814(a)(2)(C) and 1835(a)(2)(A), nursing care and home health aide services shall be considered to be provided or needed on an 'intermittent' basis if they are provided or needed less than 7 days each week and, in the case they are provided or needed for 7 days each week, if they are provided or needed for a period of up to 38 consecutive days.", applicable to services furnished in cases of initial periods of home health services beginning on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out that sentence, effective January 1, 1990.

Home Health Agency[672]

(o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

(3) maintains clinical records on all patients;

(4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;

(5) has in effect an overall plan and budget that meets the requirements of subsection (z);

(6) meets the conditions of participation specified in section 1891(a) and[673] such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization; and

(7) meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Secretary finds necessary for the financial security of the program) as the Secretary finds necessary for the effective and efficient operation of the program;

except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.

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[670] P.L. 100-360, §411(d)(1)(B)(i), inserted "; except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment", applicable to equipment furnished on or after June 1, 1989.

[671] P.L. 101-508, §4152(a)(2), added this sentence, applicable to items furnished on or after January 1, 1991.

[672] See Vol. II, P.L. 78-410, §339, with respect to home health services.

[673] P.L. 100-203, §4021(a), inserted "the conditions of participation specified in section 1891(a) and", applicable to home health agencies as of June 1, 1989.

Outpatient Physical Therapy Services

(p) The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

(1) who is under the care of a physician (as defined in paragraph (1) or (3) of section 1861(r)), and

(2) with respect to whom a plan prescribing the type, amount, and duration of physical therapy services that are to be furnished such individual has been established by a physician (as so defined) or by a qualified physical therapist and is periodically reviewed by a physician (as so defined);

excluding, however—

(3) any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital; and

(4) any such service—

(A) if furnished by a clinic or rehabilitation agency, or by others under arrangements with such clinic or agency, unless such clinic or rehabilitation agency—

(i) provides an adequate program of physical therapy services for outpatients and has the facilities and personnel required for such program or required for the supervision of such a program, in accordance with such requirements as the Secretary may specify,

(ii) has policies, established by a group of professional personnel, including one or more physicians (associated with the clinic or rehabilitation agency) and one or more qualified physical therapists, to govern the services (referred to in clause (i)) it provides,

(iii) maintains clinical records on all patients,

(iv) if such clinic or agency is situated in a State in which State or applicable local law provides for the licensing of institutions of this nature, (I) is licensed pursuant to such law, or (II) is approved by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

(v) meets such other conditions relating to the health and safety of individuals who are furnished services by such clinic or agency on an outpatient basis, as the Secretary may find necessary, or

(B) if furnished by a public health agency, unless such agency meets such other conditions relating to health and safety of individuals who are furnished services by such agency on an outpatient basis, as the Secretary may find necessary.

The term "outpatient physical therapy services" also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary. In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or extended care facility. The term "outpatient physical therapy services" also includes speech pathology services furnished by a provider of services, a clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection. Nothing in this subsection shall be construed as requiring, with respect to outpatients who are not entitled to benefits under this title, a physical therapist to provide outpatient physical therapy services only to outpatients who are under the care of a physician or pursuant to a plan of care established by a physician.

Physicians' Services

(q) The term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not including services described in subsection (b)(6)).

Physician

(r) The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a doctor of optometry, but only with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;

(B) hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) incident to physicians' services rendered to outpatients and partial hospitalization services incident to such services;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

(D) outpatient physical therapy services and outpatient occupational therapy services;

(E) rural health clinic services and Federally qualified health center services[674];

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies;

(G) antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in section 1861(r)(1), for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician;

(H)(i) services furnished pursuant to a contract under section 1876 to a member of an eligible organization by a physician assistant or by a nurse practitioner (as defined in subsection (aa)(5)[675]) and such services and supplies furnished as an incident to his service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service; and

(ii) services furnished pursuant to a risk-sharing contract under section 1876(g) to a member of an eligible organization by a clinical psychologist (as defined by the Secretary) or by a clinical social worker (as defined in subsection (hh)(2)[676]), and such services and supplies furnished as an incident to such clinical psychologist's services or clinical social worker's services to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;

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[674] P.L. 101-508, §4161(a)(1), inserted "and Federally qualified health center services". [For the effective date, see Vol. II, P.L. 101-508, §4161(a)(8).]

[675] P.L. 101-508, §4161(a)(5)(A), struck out "(3)" and substituted "(5)". [For the effective date, see Vol. II, P.L. 101-508, §4161(a)(8).]

(I) blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, subject to utilization controls deemed necessary by the Secretary for the efficient use of such factors;

(J) prescription drugs used in immunosuppressive therapy furnished, to an individual who receives an organ transplant for which payment is made under this title, within 1 year after the date of the transplant procedure;[677]

(K)(i) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a physician assistant (as defined in subsection (aa)(5)[678]) under the supervision of a physician (as so defined) (I) in a hospital, skilled nursing facility, or nursing facility (as defined in section 1919(a)), (II) as an assistant at surgery, or (III) in a rural area (as defined in section 1886(d)(2)(D)) that is designated, under section 332(a)(1)(A) of the Public Health Service Act[679], as a health professional[680] shortage area, and which the physician assistant is legally authorized to perform by the State in which the services are performed,[681]

(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner (as defined in subsection (aa)(5)[682]) working in collaboration (as defined in subsection (aa)(6)[683]) with a physician (as defined in subsection (r)(1)) in a skilled nursing facility or nursing facility (as defined in section 1919(a)) which the nurse practitioner is legally authorized to perform by the State in which the services are performed,[684]

(iii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(3)) working in collaboration (as defined in subsection (aa)(4)) with a physician (as defined in subsection

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[676] P.L. 101-239, §6113(b)(2)(A), struck out "(hh)" and substituted "(hh)(2)", applicable to services furnished on or after July 1, 1990.

[677] P.L. 100-360, §202(a)(1), amended subparagraph (J) in its entirety, applicable to items dispensed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), amended subparagraph (J) in its entirety, effective January 1, 1990. [For subparagraph (J) as it formerly read, see Vol. III, P.L. 101-234.]

P.L. 101-239, §6114(a)(1), struck out "and". Impossible to execute.

[678] P.L. 101-508, §4161(a)(5)(A), struck out "(3)" and substituted "(5)". [For the effective date, see Vol. II, P.L. 101-508, §4161(a)(8).]

[679] P.L. 78-410.

[680] P.L. 101-597, §401(c)(2), struck out "manpower" and substituted "professional", effective November 16, 1990.

[681] P.L. 101-239, §6114(a)(2)(A), struck out "and".

[682] P.L. 101-508, §4161(a)(5)(A), struck out "(3)" and substituted "(5)". [For the effective date, see Vol. II, P.L. 101-508, §4161(a)(8).]

[683] P.L. 101-508, §4161(a)(5)(A), struck out "(4)" and substituted "(6)". [For the effective date, see Vol. II, P.L. 101-508, §4161(a)(8).]

[684] P.L. 101-239, §6114(a)(2)(D), added this clause (ii), applicable to services furnished on or after April 1, 1990.

P.L. 101-508, §4155(a)(1), struck out "and".

(r)(1)) in a rural area (as defined in section 1886(d)(2)(D)) which the nurse practitioner or clinical nurse specialist is authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service, and[685]

(iv)[686] such services and supplies furnished as an incident to services described in clause (i) or (ii)[687] as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service;[688]

(L) certified nurse-midwife services;[689]

(M) qualified psychologist services;[690]

(N) clinical social worker services (as defined in subsection (hh)(2));[691]

(O) a covered osteoporosis drug and its administration (as defined in subsection (jj)) furnished on or after January 1, 1991, and on or before December 31, 1995; and[692]

(P) erythropoietin for home dialysis patients competent to use such drug without medical or other supervision with respect to the administration of such drug, subject to methods and standards established by the Secretary by regulation for the safe and effective use of such drug, and items related to the administration of such drug;[693]

(3) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary), diagnostic laboratory tests, and other diagnostic tests;

(4) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

(5) surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;

(6) durable medical equipment;[694]

(7) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;

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[685] P.L. 101-508, §4155(a)(3), added this clause (iii), applicable to services furnished on or after January 1, 1991.

[686] P.L. 101-239, §6114(a)(2)(C), redesignated clause (ii) as clause (iii).

P.L. 101-508, §4155(a)(2), redesignated clause (iii) as clause (iv).

[687] P.L. 101-239, §6114(a)(2)(B), struck out "such services" and substituted "services described in clause (i) or (ii)", applicable to services furnished on or after April 1, 1990.

[688] See Vol. II, P.L. 99-509, §9338(d), with respect to reduction in payment to avoid duplicate payment.

[689] P.L. 101-239, §6113(b)(1)(A), struck out "and".

[690] P.L. 101-239, §6113(b)(1)(B), added "and".

P.L. 101-508, §4156(a)(1)(A), struck out "and".

[691] P.L. 101-239, §6113(b)(1)(C), added subparagraph (N), applicable to services furnished on or after July 1, 1990.

P.L. 101-508, §4156(a)(1)(B), inserted "and".

P.L. 101-508, §4201(d)(1)(A), struck out "and".

[692] P.L. 101-508, §4156(a)(1)(C), added subparagraph (O), effective November 5, 1990.

P.L. 101-508, §4201(d)(1)(B), added "and".

[693] P.L. 101-508, §4201(d)(1)(C), added subparagraph (P), applicable to items and services furnished on or after July 1, 1991. Margin as in original.

[694] See Vol. II, P.L. 92-603, §245, with respect to authorization to conduct reimbursement experiments.

See Vol. II, P.L. 100-647, §8427, with respect to payment for medical escort or medical attendant on a commercial airliner.

(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens[695];

(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition;

(10)(A) pneumococcal vaccine and its administration and, subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987[696], influenza vaccine and its administration[697]; and

(B) hepatitis B vaccine and its administration, furnished to an individual who is at high or intermediate risk of contracting hepatitis B (as determined by the Secretary under regulations);

(11) services of a certified registered nurse anesthetist (as defined in subsection (bb));[698]

(12) subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, extra-depth shoes with inserts or custom molded shoes with inserts[699] for an individual with diabetes, if—

(A) the physician who is managing the individual's diabetic condition (i) documents that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation, and (ii) certifies that the individual needs such shoes under a comprehensive plan of care related to the individual's diabetic condition;

(B) the particular type of shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary); and

(C) the shoes are fitted and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician described in subparagraph (A) (unless the Secretary finds that the physician is the only such qualified individual in the area); and[700]

(13) screening mammography (as defined in subsection (jj));[701]

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[695] P.L. 101-508, §4153(b)(2)(A), inserted ", and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens", applicable to items furnished on or after January 1, 1991.

[696] P.L. 100-203.

[697] See Vol. II, P.L. 100-203, §4071(b), with respect to application of the contingent effective date of the demonstration project.

[698] P.L. 99-509, §9320(b)(4), added this paragraph (11). For the effective date, see Vol. II, P.L. 99-509, §9320(i), as amended by P.L. 100-485.

P.L. 101-234, §201(a)(1), added "and".

P.L. 101-508, §4163(a)(1)(A), struck out "and".

[699] P.L. 101-239, §6131(a)(2), inserted "with inserts", applicable with respect to therapeutic shoes and inserts furnished on or after July 1, 1989. In applying this amendment, the increase under §1833(o)(2)(C) shall apply to the dollar amounts specified under §1833(o)(2)(A) (as amended) in the same manner as the increase would have been applied to the dollar amounts specified under §1833(o)(2)(A) (as in effect before December 19, 1989).

[700] P.L. 100-203, §4072(a)(4), added this paragraph (12). For the effective date, see Vol. II, P.L. 100-203, §4072(e).

P.L. 101-234, §201(a)(1), struck out "; and" and substituted a period, effective January 1, 1990.

P.L. 101-239, §6115(a)(1)(A), struck out "and". Impossible to execute.

P.L. 101-508, §4163(a)(1)(B), struck out a period and substituted "; and".

[701] P.L. 100-360, §204(a)(1)(D), added paragraph (13), applicable to screening mammography performed on or after January 1, 1990.

(14) screening pap smear.[702]

No diagnostic tests performed in any laboratory, including a laboratory that is part of[703] a rural health clinic, or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1814(d)) shall be included within paragraph (3) unless such laboratory—

(15)[704] if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

(16)(A) meets the certification requirements under section 353 of the Public Health Service Act[705]; and[706]

(B)[707] meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2)(C) any item or service (except services referred to in paragraph (1)) which would not be included under subsection (b) if it were furnished to an inpatient of a hospital. None of the items and services referred to in the preceding paragraphs (other than paragraphs (1) and (2)(A)) of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1814(d) shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.

Drugs and Biologicals

(t)[708] The term "drugs" and the term "biologicals", except for

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P.L. 101-234, §201(a)(1), struck out paragraph (13), effective January 1, 1990. [For paragraph (13) as it formerly read, see Vol. III, P.L. 101-234.]

P.L. 101-508, §4163(a)(1)(C), added this paragraph (13), applicable to screening mammography performed on or after January 1, 1991.

[702] P.L. 101-239, §6115(a)(1)(D), added this subparagraph, applicable to screening pap smears performed on or after July 1, 1990.

[703] P.L. 100-203, §4064(e)(1), inserted "a laboratory not independent of a physician's office that has a volume of clinical diagnostic laboratory tests exceeding 5,000 per year, ", applicable to diagnostic tests performed on or after January 1, 1990.

P.L. 101-239, §6141(a)(1), struck out "which is independent of a physician's office, a laboratory not independent of a physician's office that has a volume of clinical diagnostic laboratory tests exceeding 5,000 per year," and substituted ", including a laboratory that is part of", effective December 19, 1989.

[704] P.L. 100-203, §4072(a)(1), redesignated the former paragraph (12) as paragraph (13). For the effective date, see Vol. II, P.L. 100-203, §4072(e).

P.L. 100-360, §204(a)(1)(A), redesignated the former paragraph (13) as paragraph (14), applicable to screening mammography performed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), redesignated the former paragraph (14) as paragraph (13), effective January 1, 1990.

P.L. 101-239, §6115(a)(1)(C), redesignated paragraph (14) as paragraph (15). Executed as if "paragraph (14)" read "paragraph (13)".

[705] P.L. 78-410.

[706] P.L. 101-239, §6141(a)(3), added subparagraph (A), effective December 19, 1989.

[707] P.L. 100-203, §4072(a)(1), redesignated the former paragraph (13) as paragraph (14). For the effective date, see Vol. II, P.L. 100-203, §4072(e).

P.L. 100-360, §204(a)(1)(A), redesignated paragraph (14) as paragraph (15), applicable to screening mammography performed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), redesignated paragraph (15) as paragraph (14), effective January 1, 1990.

P.L. 101-239, §6115(a)(1)(C), redesignated paragraph (15) as paragraph (16). Executed as if "paragraph (15)" read "paragraph (14)".

P.L. 101-239, §6141(a)(2), redesignated paragraph (16) as subparagraph (B).

[708] P.L. 101-234, §201(a)(1) struck out "(1)".

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection.[662] For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), section 1814(f)(2), and subsection (i) of this section[663], such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r), to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2),[664] include any institution which is primarily for the care and treatment of mental diseases unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—

(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall provide for temporary waiver of the requirements, for such period as the Secretary deems appropriate, where (i) the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area in which the facility is located, (ii) a registered professional nurse is present on the premises to render or supervise the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients;

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[662] P.L. 101-234, §101(a)(1), inserted "For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection.", effective January 1, 1990. For the applicability of this amendment, see Vol. II, P.L. 100-360, §104(a).

[663] P.L. 101-234, §101(a)(1), struck out "and section 1814(f)(2)" and substituted "section 1814(f)(2), and subsection (i) of this section", effective January 1, 1990. For the applicability of this amendment, see Vol. II, P.L. 100-360, §104(a).

[664] P.L. 101-234, §101(a)(1), inserted ", except for purposes of subsection (a)(2),", effective January 1, 1990. For the applicability of this amendment, see Vol. II, P.L. 100-360, §104(a).

(B) with respect to the health and safety requirements promulgated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such manner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facility is located, and the scope of services rendered by such facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such personnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the personnel requirements, (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the health and safety of patients, and (iii) if the Secretary has determined that because of the facility's waiver under this subparagraph the facility should limit its scope of services in order not to adversely affect the health and safety of the facility's patients, the facility is so limiting the scope of services it provides; and

(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary (i) may waive, for such period as he deems appropriate, specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for such a facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.

The term "hospital" does not include, unless the context otherwise requires, a rural primary care hospital (as defined in section 1861(mm)(1)).[665]

Psychiatric Hospital

(f) The term "psychiatric hospital" means an institution which—

(1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);

(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under part A; and

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[665] P.L. 101-239, §6003(g)(3)(D)(x)(I), added this sentence, effective December 19, 1989.

(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a "psychiatric hospital".

Outpatient Occupational Therapy Services

(g) The term "outpatient occupational therapy services" has the meaning given the term "outpatient physical therapy services" in subsection (p), except that "occupational" shall be substituted for "physical" each place it appears therein.

Extended Care Services

(h) The term "extended care services" means the following items and services furnished to an inpatient of a skilled nursing facility and (except as provided in paragraphs (3) and (6)) by such skilled nursing facility—

(1) nursing care provided by or under the supervision of a registered professional nurse;

(2) bed and board in connection with the furnishing of such nursing care;

(3) physical, occupational, or speech therapy furnished by the skilled nursing facility or by others under arrangements with them made by the facility;

(4) medical social services;

(5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility, as are ordinarily furnished by such facility for the care and treatment of inpatients;

(6) medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of subsection (l)), under a teaching program of such hospital approved as provided in the last sentence of subsection (b), and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and

(7) such other services necessary to the health of the patients as are generally provided by skilled nursing facilities;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

Post-Hospital Extended Care Services[666]

(i) The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility (A) within 30 days after discharge from such hospital, or (B) within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 30 days after discharge from a hospital; and an individual shall be deemed not to have been discharged from a skilled nursing facility if, within 30 days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.

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[666] P.L. 101-234, §101(a)(1), added subsection (i), effective January 1, 1990. For the applicability of this amendment, see Vol. II, P.L. 100-360, §104(a).

Skilled Nursing Facility[667]

(j) The term "skilled nursing facility" has the meaning given such term in section 1819(a).

Utilization Review

(k) A utilization review plan of a hospital or skilled nursing facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this title and if it provides—

(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

(2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians (of which at least two must be physicians described in subsection (r)(1) of this section), with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after opportu-

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[667] P.L. 100-203, §4201(a)(1), amended subsection (j) in its entirety. For the effective date, see Vol. II, P.L. 100-203, §4204(a). [For subsection (j) as it formerly read, see Vol. III, P.L. 100-203.]

Effective July 1, 1988, and until the effective date of §1819(c), §1861(j) is deemed to include the requirement described in §1819(c)(3)(A) (as added by §4201(a)(3) of the Omnibus Budget Reconciliation Act of 1987).

nity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or skilled nursing facility where, because of the small size of the institution, or (in the case of a skilled nursing facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection. If the Secretary determines that the utilization review procedures established pursuant to title XIX are superior in their effectiveness to the procedures required under this section, he may, to the extent that he deems it appropriate, require for purposes of this title that the procedures established pursuant to title XIX be utilized instead of the procedures required by this section.

Agreements for Transfer Between Skilled Nursing Facilities and Hospitals

(l) A hospital and a skilled nursing facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

(1) transfer of patients will be effected between the hospital and the skilled nursing facility whenever such transfer is medically appropriate as determined by the attending physician; and

(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any skilled nursing facility which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under section 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this title.

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical, occupational, or speech therapy;

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary;

(5) medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care, but excluding drugs and biologicals) and durable medical equipment while under such a plan;[668]

(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A),

but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.[669]

Durable Medical Equipment

(n) The term "durable medical equipment" includes iron lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe) used in the patient's home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) of this section or section 1819(a)(1)), whether furnished on a rental basis or purchased; except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment[670]. With respect to a seat-lift chair, such term includes only the seat-lift mechanism and does not include the chair.[671]

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[668] P.L. 101-239, §6112(e)(1), amended paragraph (5) in its entirety, applicable with respect to items furnished on or after January 1, 1990. [For paragraph (5) as it formerly read, see Vol. III, P.L. 101-239.]

[669] P.L. 100-360, §206(a), added "For purposes of paragraphs (1) and (4) and sections 1814(a)(2)(C) and 1835(a)(2)(A), nursing care and home health aide services shall be considered to be provided or needed on an 'intermittent' basis if they are provided or needed less than 7 days each week and, in the case they are provided or needed for 7 days each week, if they are provided or needed for a period of up to 38 consecutive days.", applicable to services furnished in cases of initial periods of home health services beginning on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out that sentence, effective January 1, 1990.

Home Health Agency[672]

(o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

(3) maintains clinical records on all patients;

(4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;

(5) has in effect an overall plan and budget that meets the requirements of subsection (z);

(6) meets the conditions of participation specified in section 1891(a) and[673] such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization; and

(7) meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Secretary finds necessary for the financial security of the program) as the Secretary finds necessary for the effective and efficient operation of the program;

except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.

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[670] P.L. 100-360, §411(d)(1)(B)(i), inserted "; except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment", applicable to equipment furnished on or after June 1, 1989.

[671] P.L. 101-508, §4152(a)(2), added this sentence, applicable to items furnished on or after January 1, 1991.

[672] See Vol. II, P.L. 78-410, §339, with respect to home health services.

[673] P.L. 100-203, §4021(a), inserted "the conditions of participation specified in section 1891(a) and", applicable to home health agencies as of June 1, 1989.

Outpatient Physical Therapy Services

(p) The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

(1) who is under the care of a physician (as defined in paragraph (1) or (3) of section 1861(r)), and

(2) with respect to whom a plan prescribing the type, amount, and duration of physical therapy services that are to be furnished such individual has been established by a physician (as so defined) or by a qualified physical therapist and is periodically reviewed by a physician (as so defined);

excluding, however—

(3) any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital; and

(4) any such service—

(A) if furnished by a clinic or rehabilitation agency, or by others under arrangements with such clinic or agency, unless such clinic or rehabilitation agency—

(i) provides an adequate program of physical therapy services for outpatients and has the facilities and personnel required for such program or required for the supervision of such a program, in accordance with such requirements as the Secretary may specify,

(ii) has policies, established by a group of professional personnel, including one or more physicians (associated with the clinic or rehabilitation agency) and one or more qualified physical therapists, to govern the services (referred to in clause (i)) it provides,

(iii) maintains clinical records on all patients,

(iv) if such clinic or agency is situated in a State in which State or applicable local law provides for the licensing of institutions of this nature, (I) is licensed pursuant to such law, or (II) is approved by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

(v) meets such other conditions relating to the health and safety of individuals who are furnished services by such clinic or agency on an outpatient basis, as the Secretary may find necessary, or

(B) if furnished by a public health agency, unless such agency meets such other conditions relating to health and safety of individuals who are furnished services by such agency on an outpatient basis, as the Secretary may find necessary.

The term "outpatient physical therapy services" also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary. In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or extended care facility. The term "outpatient physical therapy services" also includes speech pathology services furnished by a provider of services, a clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection. Nothing in this subsection shall be construed as requiring, with respect to outpatients who are not entitled to benefits under this title, a physical therapist to provide outpatient physical therapy services only to outpatients who are under the care of a physician or pursuant to a plan of care established by a physician.

Physicians' Services

(q) The term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not including services described in subsection (b)(6)).

Physician

(r) The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a doctor of optometry, but only with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;

(B) hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) incident to physicians' services rendered to outpatients and partial hospitalization services incident to such services;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

(D) outpatient physical therapy services and outpatient occupational therapy services;

(E) rural health clinic services and Federally qualified health center services[674];

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies;

(G) antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in section 1861(r)(1), for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician;

(H)(i) services furnished pursuant to a contract under section 1876 to a member of an eligible organization by a physician assistant or by a nurse practitioner (as defined in subsection (aa)(5)[675]) and such services and supplies furnished as an incident to his service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service; and

(ii) services furnished pursuant to a risk-sharing contract under section 1876(g) to a member of an eligible organization by a clinical psychologist (as defined by the Secretary) or by a clinical social worker (as defined in subsection (hh)(2)[676]), and such services and supplies furnished as an incident to such clinical psychologist's services or clinical social worker's services to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;

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[674] P.L. 101-508, §4161(a)(1), inserted "and Federally qualified health center services". [For the effective date, see Vol. II, P.L. 101-508, §4161(a)(8).]

[675] P.L. 101-508, §4161(a)(5)(A), struck out "(3)" and substituted "(5)". [For the effective date, see Vol. II, P.L. 101-508, §4161(a)(8).]

(I) blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, subject to utilization controls deemed necessary by the Secretary for the efficient use of such factors;

(J) prescription drugs used in immunosuppressive therapy furnished, to an individual who receives an organ transplant for which payment is made under this title, within 1 year after the date of the transplant procedure;[677]

(K)(i) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a physician assistant (as defined in subsection (aa)(5)[678]) under the supervision of a physician (as so defined) (I) in a hospital, skilled nursing facility, or nursing facility (as defined in section 1919(a)), (II) as an assistant at surgery, or (III) in a rural area (as defined in section 1886(d)(2)(D)) that is designated, under section 332(a)(1)(A) of the Public Health Service Act[679], as a health professional[680] shortage area, and which the physician assistant is legally authorized to perform by the State in which the services are performed,[681]

(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner (as defined in subsection (aa)(5)[682]) working in collaboration (as defined in subsection (aa)(6)[683]) with a physician (as defined in subsection (r)(1)) in a skilled nursing facility or nursing facility (as defined in section 1919(a)) which the nurse practitioner is legally authorized to perform by the State in which the services are performed,[684]

(iii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(3)) working in collaboration (as defined in subsection (aa)(4)) with a physician (as defined in subsection

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[676] P.L. 101-239, §6113(b)(2)(A), struck out "(hh)" and substituted "(hh)(2)", applicable to services furnished on or after July 1, 1990.

[677] P.L. 100-360, §202(a)(1), amended subparagraph (J) in its entirety, applicable to items dispensed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), amended subparagraph (J) in its entirety, effective January 1, 1990. [For subparagraph (J) as it formerly read, see Vol. III, P.L. 101-234.]

P.L. 101-239, §6114(a)(1), struck out "and". Impossible to execute

[678] P.L. 101-508, §4161(a)(5)(A), struck out "(3)" and substituted "(5)". [For the effective date, see Vol. II, P.L. 101-508, §4161(a)(8).]

[679] P.L. 78-410.

[680] P.L. 101-597, §401(c)(2), struck out "manpower" and substituted "professional", effective November 16, 1990.

[681] P.L. 101-239, §6114(a)(2)(A), struck out "and".

[682] P.L. 101-508, §4161(a)(5)(A), struck out "(3)" and substituted "(5)". [For the effective date, see Vol. II, P.L. 101-508, §4161(a)(8).]

[683] P.L. 101-508, §4161(a)(5)(A), struck out "(4)" and substituted "(6)". [For the effective date, see Vol. II, P.L. 101-508, §4161(a)(8).]

[684] P.L. 101-239, §6114(a)(2)(D), added this clause (ii), applicable to services furnished on or after April 1, 1990.

P.L. 101-508, §4155(a)(1), struck out "and".

(r)(1)) in a rural area (as defined in section 1886(d)(2)(D)) which the nurse practitioner or clinical nurse specialist is authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service, and[685]

(iv)[686] such services and supplies furnished as an incident to services described in clause (i) or (ii)[687] as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service;[688]

(L) certified nurse-midwife services;[689]

(M) qualified psychologist services;[690]

(N) clinical social worker services (as defined in subsection (hh)(2));[691]

(O) a covered osteoporosis drug and its administration (as defined in subsection (jj)) furnished on or after January 1, 1991, and on or before December 31, 1995; and[692]

(P) erythropoietin for home dialysis patients competent to use such drug without medical or other supervision with respect to the administration of such drug, subject to methods and standards established by the Secretary by regulation for the safe and effective use of such drug, and items related to the administration of such drug;[693]

(3) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary), diagnostic laboratory tests, and other diagnostic tests;

(4) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

(5) surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;

(6) durable medical equipment;[694]

(7) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;

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[685] P.L. 101-508, §4155(a)(3), added this clause (iii), applicable to services furnished on or after January 1, 1991.

[686] P.L. 101-239, §6114(a)(2)(C), redesignated clause (ii) as clause (iii).

P.L. 101-508, §4155(a)(2), redesignated clause (iii) as clause (iv).

[687] P.L. 101-239, §6114(a)(2)(B), struck out "such services" and substituted "services described in clause (i) or (ii)", applicable to services furnished on or after April 1, 1990.

[688] See Vol. II, P.L. 99-509, §9338(d), with respect to reduction in payment to avoid duplicate payment.

[689] P.L. 101-239, §6113(b)(1)(A), struck out "and".

[690] P.L. 101-239, §6113(b)(1)(B), added "and".

P.L. 101-508, §4156(a)(1)(A), struck out "and".

[691] P.L. 101-239, §6113(b)(1)(C), added subparagraph (N), applicable to services furnished on or after July 1, 1990.

P.L. 101-508, §4156(a)(1)(B), inserted "and".

P.L. 101-508, §4201(d)(1)(A), struck out "and".

[692] P.L. 101-508, §4156(a)(1)(C), added subparagraph (O), effective November 5, 1990.

P.L. 101-508, §4201(d)(1)(B), added "and".

[693] P.L. 101-508, §4201(d)(1)(C), added subparagraph (P), applicable to items and services furnished on or after July 1, 1991. Margin as in original.

[694] See Vol. II, P.L. 92-603, §245, with respect to authorization to conduct reimbursement experiments.

See Vol. II, P.L. 100-647, §8427, with respect to payment for medical escort or medical attendant on a commercial airliner.

(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens[695];

(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition;

(10)(A) pneumococcal vaccine and its administration and, subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987[696], influenza vaccine and its administration[697]; and

(B) hepatitis B vaccine and its administration, furnished to an individual who is at high or intermediate risk of contracting hepatitis B (as determined by the Secretary under regulations);

(11) services of a certified registered nurse anesthetist (as defined in subsection (bb));[698]

(12) subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, extra-depth shoes with inserts or custom molded shoes with inserts[699] for an individual with diabetes, if—

(A) the physician who is managing the individual's diabetic condition (i) documents that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation, and (ii) certifies that the individual needs such shoes under a comprehensive plan of care related to the individual's diabetic condition;

(B) the particular type of shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary); and

(C) the shoes are fitted and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician described in subparagraph (A) (unless the Secretary finds that the physician is the only such qualified individual in the area); and[700]

(13) screening mammography (as defined in subsection (jj));[701]

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[695] P.L. 101-508, §4153(b)(2)(A), inserted ", and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens", applicable to items furnished on or after January 1, 1991.

[696] P.L. 100-203.

[697] See Vol. II, P.L. 100-203, §4071(b), with respect to application of the contingent effective date of the demonstration project.

[698] P.L. 99-509, §9320(b)(4), added this paragraph (11). For the effective date, see Vol. II, P.L. 99-509, §9320(i), as amended by P.L. 100-485.

P.L. 101-234, §201(a)(1), added "and".

P.L. 101-508, §4163(a)(1)(A), struck out "and".

[699] P.L. 101-239, §6131(a)(2), inserted "with inserts", applicable with respect to therapeutic shoes and inserts furnished on or after July 1, 1989. In applying this amendment, the increase under §1833(o)(2)(C) shall apply to the dollar amounts specified under §1833(o)(2)(A) (as amended) in the same manner as the increase would have been applied to the dollar amounts specified under §1833(o)(2)(A) (as in effect before December 19, 1989).

[700] P.L. 100-203, §4072(a)(4), added this paragraph (12). For the effective date, see Vol. II, P.L. 100-203, §4072(e).

P.L. 101-234, §201(a)(1), struck out "; and" and substituted a period, effective January 1, 1990.

P.L. 101-239, §6115(a)(1)(A), struck out "and". Impossible to execute.

P.L. 101-508, §4163(a)(1)(B), struck out a period and substituted "; and".

[701] P.L. 100-360, §204(a)(1)(D), added paragraph (13), applicable to screening mammography performed on or after January 1, 1990.

(14) screening pap smear.[702]

No diagnostic tests performed in any laboratory, including a laboratory that is part of[703] a rural health clinic, or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1814(d)) shall be included within paragraph (3) unless such laboratory—

(15)[704] if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

(16)(A) meets the certification requirements under section 353 of the Public Health Service Act[705]; and[706]

(B)[707] meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2)(C) any item or service (except services referred to in paragraph (1)) which would not be included under subsection (b) if it were furnished to an inpatient of a hospital. None of the items and services referred to in the preceding paragraphs (other than paragraphs (1) and (2)(A)) of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1814(d) shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.

Drugs and Biologicals

(t)[708] The term "drugs" and the term "biologicals", except for

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P.L. 101-234, §201(a)(1), struck out paragraph (13), effective January 1, 1990. [For paragraph (13) as it formerly read, see Vol. III, P.L. 101-234.]

P.L. 101-508, §4163(a)(1)(C), added this paragraph (13), applicable to screening mammography performed on or after January 1, 1991.

[702] P.L. 101-239, §6115(a)(1)(D), added this subparagraph, applicable to screening pap smears performed on or after July 1, 1990.

[703] P.L. 100-203, §4064(e)(1), inserted "a laboratory not independent of a physician's office that has a volume of clinical diagnostic laboratory tests exceeding 5,000 per year, ", applicable to diagnostic tests performed on or after January 1, 1990.

P.L. 101-239, §6141(a)(1), struck out "which is independent of a physician's office, a laboratory not independent of a physician's office that has a volume of clinical diagnostic laboratory tests exceeding 5,000 per year," and substituted ", including a laboratory that is part of", effective December 19, 1989.

[704] P.L. 100-203, §4072(a)(1), redesignated the former paragraph (12) as paragraph (13). For the effective date, see Vol. II, P.L. 100-203, §4072(e).

P.L. 100-360, §204(a)(1)(A), redesignated the former paragraph (13) as paragraph (14), applicable to screening mammography performed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), redesignated the former paragraph (14) as paragraph (13), effective January 1, 1990.

P.L. 101-239, §6115(a)(1)(C), redesignated paragraph (14) as paragraph (15). Executed as if "paragraph (14)" read "paragraph (13)".

[705] P.L. 78-410.

[706] P.L. 101-239, §6141(a)(3), added subparagraph (A), effective December 19, 1989.

[707] P.L. 100-203, §4072(a)(1), redesignated the former paragraph (13) as paragraph (14). For the effective date, see Vol. II, P.L. 100-203, §4072(e).

P.L. 100-360, §204(a)(1)(A), redesignated paragraph (14) as paragraph (15), applicable to screening mammography performed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), redesignated paragraph (15) as paragraph (14), effective January 1, 1990.

P.L. 101-239, §6115(a)(1)(C), redesignated paragraph (15) as paragraph (16). Executed as if "paragraph (15)" read "paragraph (14)".

P.L. 101-239, §6141(a)(2), redesignated paragraph (16) as subparagraph (B).

[708] P.L. 101-234, §201(a)(1) struck out "(1)".

purposes of subsection (m)(5) [709] of this section, include only such drugs and biologicals, respectively, as are included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.

[(2) Repealed.[710]]

[(3) Repealed.[711]]

[(4) Repealed.[712]]

Provider of Services

(u) The term "provider of services" means a hospital, rural primary care hospital,[713] skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program,[714] or, for purposes of section 1814(g) and section 1835(e), a fund.

Reasonable Cost

(v)(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

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[709] P.L. 100-360, §202(a)(2)(A), inserted "and paragraph (2)", applicable to items dispensed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "and paragraph (2)", effective January 1, 1990.

[710] P.L. 100-360, §202(a)(2)(C), added this paragraph, applicable to items dispensed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed this paragraph, effective January 1, 1990. [For this paragraph as it formerly read, see Vol. III, P.L. 101-234.]

[711] P.L. 100-360, §202(a)(2)(C), added this paragraph, applicable to items dispensed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed this paragraph, effective January 1, 1990. [For this paragraph as it formerly read, see Vol. III, P.L. 101-234.]

[712] P.L. 100-360, §202(a)(2)(C), added this paragraph, applicable to items dispensed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed this paragraph, effective January 1, 1990. [For this paragraph as it formerly read, see Vol. III, P.L. 101-234.]

[713] P.L. 101-239, §6003(g)(3)(C)(i), inserted "rural primary care hospital,", effective December 19, 1989.

[714] P.L. 100-360, §203(e)(1), inserted "home intravenous drug therapy provider,", applicable to items and services furnished on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "home intravenous drug therapy provider,", effective January 1, 1990.

(B) Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any cost reporting period shall be equal to the average of the rates of interest, for each of the months any part of which is included in the period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(C) Where a hospital has an arrangement with a medical school under which the faculty of such school provides services at such hospital, an amount not in excess of the reasonable cost of such services to the medical school shall be included in determining the reasonable cost to the hospital of furnishing services—

(i) for which payment may be made under part A, but only if—

(I) payment for such services as furnished under such arrangement would be made under part A to the hospital had such services been furnished by the hospital, and

(II) such hospital pays to the medical school at least the reasonable cost of such services to the medical school, or

(ii) for which payment may be made under part B, but only if such hospital pays to the medical school at least the reasonable cost of such services to the medical school.

(D) Where (i) physicians furnish services which are either inpatient hospital services (including services in conjunction with the teaching programs of such hospital) by reason of paragraph (7) of subsection (b) or for which entitlement exists by reason of clause (II) of section 1832(a)(2)(B)(i), and (ii) such hospital (or medical school under arrangement with such hospital) incurs no actual cost in the furnishing of such services, the reasonable cost of such services shall (under regulations of the Secretary) be deemed to be the cost such hospital or medical school would have incurred had it paid a salary to such physicians rendering such services approximately equivalent to the average salary paid to all physicians employed by such hospital (or if such employment does not exist, or is minimal in such hospital, by similar hospitals in a geographic area of sufficient size to assure reasonable inclusion of sufficient physicians in development of such average salary).

(E) Such regulations may, in the case of skilled nursing facilities in any State, provide for the use of rates, developed by the State in which such facilities are located, for the payment of the cost of skilled nursing facility services furnished under the State's plan approved under title XIX (and such rates may be increased by the Secretary on a class or size of institution or on a geographical basis by a percentage factor not in excess of 10 percent to take into account determinable items or services or other requirements under this title not otherwise included in the computation of such State rates), if the Secretary finds that such rates are reasonably related to (but not necessarily limited to) analyses undertaken by such State of costs of care in comparable facilities in such State. Notwithstanding the previous sentence, such regulations with respect to skilled nursing facilities shall take into account (in a manner consistent with subparagraph (A) and based on patient-days of services furnished) the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title)[715] of such facilities complying with the requirements of subsections (b), (c), and (d) of section 1819 (including the costs of conducting nurse aide training and competency evaluation programs and competency evaluation programs).[716]

(F) Such regulations shall require each provider of services (other than a fund) to make reports to the Secretary of information described in section 1121(a) in accordance with the uniform reporting system (established under such section) for that type of provider.

(G)(i) In any case in which a hospital provides inpatient services to an individual that would constitute post-hospital[717] extended care services if provided by a skilled nursing facility and a quality control and peer review organization (or, in the absence of such a qualified organization, the Secretary or such agent as the Secretary may designate) determines that inpatient hospital services for the individual are not medically necessary but post-hospital[718] extended care services for the individual are medically necessary and such extended care services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this title at the payment rate described in clause (ii) during the period in which—

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[715] P.L. 101-508, §4008(h)(2)(A)(i), inserted "(including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title)", effective as if included in the enactment of P.L. 100-203.

[716] P.L. 100-203, §4201(b)(1), added this sentence. For the effective date, see Vol. II, P.L. 100-203, §4204(a).

[717] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.

[718] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.

(I) such post-hospital[719] extended care services for the individual are medically necessary and not otherwise available to the individual (as so determined),

(II) inpatient hospital services for the individual are not medically necessary, and

(III) the individual is entitled to have payment made for post-hospital[720] extended care services under this title,

except that if the Secretary determines that there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital, such payment shall be made (during such period) on the basis of the amount otherwise payable under part A with respect to inpatient hospital services.

(ii)(I) Except as provided in subclause (II), the payment rate referred to in clause (i) is a rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State plan approved under title XIX for the State in which such hospital is located, or, if the State in which the hospital is located does not have a State plan approved under title XIX, the estimated adjusted State-wide average allowable costs per patient-day for extended care services under this title in that State.

(II) If a hospital has a unit which is a skilled nursing facility, the payment rate referred to in clause (i) for the hospital is a rate equal to the lesser of the rate described in subclause (I) or the allowable costs in effect under this title for extended care services provided to patients of such unit.

(iii) Any day on which an individual receives inpatient services for which payment is made under this subparagraph shall, for purposes of this Act (other than this subparagraph), be deemed to be a day on which the individual received inpatient hospital services.

(iv) In determining under clause (i), in the case of a public hospital, whether or not there is an excess of hospital beds in the area of such hospital, such determination shall be made on the basis of only the public hospitals (including the hospital) which are in the area of the hospital and which are under common ownership with that hospital.

(H) In determining such reasonable cost with respect to home health agencies, the Secretary may not include—

(i) any costs incurred in connection with bonding or establishing an escrow account by any such agency as a result of the financial security requirement described in subsection (o)(7);

(ii) in the case of home health agencies to which the financial security requirement described in subsection (o)(7) applies, any costs attributed to interest charged such an agency in connection with amounts borrowed by the agency to repay overpayments made under this title to the agency, except that such costs may be included in reasonable cost if the Secretary determines that the agency was acting in good faith in borrowing the amounts;

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[719] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.

[720] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.

(iii) in the case of contracts entered into by a home health agency after the date of the enactment of this subparagraph[721] for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract which is entered into for a period exceeding five years; and

(iv) in the case of contracts entered into by a home health agency before the date of the enactment of this subparagraph[722] for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract, which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency, to the extent that such cost exceeds the reasonable value of the services furnished on behalf of such agency.

(I) In determining such reasonable cost, the Secretary may not include any costs incurred by a provider with respect to any services furnished in connection with matters for which payment may be made under this title and furnished pursuant to a contract between the provider and any of its subcontractors which is entered into after the date of the enactment of this subparagraph[723] and the value or cost of which is $10,000 or more over a twelve-month period unless the contract contains a clause to the effect that—

(i) until the expiration of four years after the furnishing of such services pursuant to such contract, the subcontractor shall make available, upon written request by the Secretary, or upon request by the Comptroller General, or any of their duly authorized representatives, the contract, and books, documents and records of such subcontractor that are necessary to certify the nature and extent of such costs, and

(ii) if the subcontractor carries out any of the duties of the contract through a subcontract, with a value or cost of $10,000 or more over a twelve-month period, with a related organization, such subcontract shall contain a clause to the effect that until the expiration of four years after the furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request by the Secretary, or upon request by the Comptroller General, or any of their duly authorized representatives, the subcontract, and books, documents and records of such organization that are necessary to verify the nature and extent of such costs.

The Secretary shall prescribe in regulation criteria and procedures which the Secretary shall use in obtaining access to books, documents, and records under clauses required in contracts and subcontracts under this subparagraph.[724]

(J) Such regulations may not provide for any inpatient routine salary cost differential as a reimbursable cost for hospitals and skilled nursing facilities.

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[721] December 5, 1980 [P.L. 96-499; 94 Stat. 2599].

[722] December 5, 1980 [P.L. 96-499; 94 Stat. 2599].

[723] December 5, 1980 [P.L. 96-499; 94 Stat. 2599].

[724] See Vol. II, P.L. 96-499, §952(b), with respect to regulations regarding access to books and records.

(K)(i) The Secretary shall issue regulations that provide, to the extent feasible, for the establishment of limitations on the amount of any costs or charges that shall be considered reasonable with respect to services provided on an outpatient basis by hospitals (other than bona fide emergency services as defined in clause (ii)) or clinics (other than rural health clinics), which are reimbursed on a cost basis or on the basis of cost related charges, and by physicians utilizing such outpatient facilities. Such limitations shall be reasonably related to the charges in the same area for similar services provided in physicians' offices. Such regulations shall provide for exceptions to such limitations in cases where similar services are not generally available in physicians' offices in the area to individuals entitled to benefits under this title.

(ii) For purposes of clause (i), the term "bona fide emergency services" means services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(I) placing the patient's health in serious jeopardy;
(II) serious impairment to bodily functions; or
(III) serious dysfunction of any bodily organ or part.

(L)(i) The Secretary, in determining the amount of the payments that may be made under this title with respect to services furnished by home health agencies, may not recognize as reasonable (in the efficient delivery of such services) costs for the provision of such services by an agency to the extent these costs exceed (on the aggregate for the agency) for cost reporting periods beginning on or after—

(I) July 1, 1985, and before July 1, 1986, 120 percent,
(II) July 1, 1986, and before July 1, 1987, 115 percent, or
(III) July 1, 1987, 112 percent,[725]

of the mean of the labor-related and nonlabor per visit costs for free standing home health agencies.

(ii) Effective for cost reporting periods beginning on or after July 1, 1986, such limitations shall be applied on an aggregate basis for the agency, rather than on a discipline specific basis, with appropriate adjustment for administrative and general costs of hospital-based agencies. The Secretary may provide for such exemptions and exceptions to such limitation as he deems appropriate.[726]

(iii) Not later than July 1, 1991, and annually thereafter, the Secretary shall establish limits under this subparagraph for cost reporting periods beginning on or after such date by utilizing the area wage index applicable under section 1886(d)(3)(E) as of such date to hospitals located in the geographic area in which the home health agency is located (determined without regard to whether such hospitals have been reclassified to a new geographic area pursuant to section 1886(d)(8)(B), a decision of the Medicare Geographic Classification Review Board under section 1886(d)(10), or a decision of the Secretary).[727]

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[725] Alignment as in original.

[726] See Vol. II, P.L. 99-509, §9315(b) with respect to considerations in establishing limits and (c) with respect to the GAO report.

[727] P.L. 101-508, §4027(sic)(d)(1), amended clause (iii) in its entirety, applicable with respect to home health agency cost reporting periods beginning on or after July 1, 1991. [For clause (iii) as it

(M) Such regulations shall provide that costs respecting care provided by a provider of services, pursuant to an assurance under title VI or XVI of the Public Health Service Act[728] that the provider will make available a reasonable volume of services to persons unable to pay therefor, shall not be allowable as reasonable costs.

(N) In determining such reasonable costs, costs incurred for activities directly related to influencing employees respecting unionization may not be included.

(O)(i) In establishing an appropriate allowance for depreciation and for interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital or skilled nursing facility which has undergone a change of ownership, such regulations shall provide, except as provided in clause (iv), that the valuation of the asset after such change of ownership shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of the date of the enactment of this subparagraph[729] (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

(ii) Such regulations shall provide for recapture of depreciation in the same manner as provided under the regulations in effect on June 1, 1984.

(iii) Such regulations shall not recognize, as reasonable in the provision of health care services, costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made under this title.

(iv) In the case of the transfer of a hospital from ownership by a State to ownership by a nonprofit corporation without monetary consideration, the basis for capital allowances to the new owner shall be the book value of the hospital to the State at the time of the transfer.[730]

(P) If such regulations provide for the payment for a return on equity capital (other than with respect to costs of inpatient hospital services), the rate of return to be recognized, for determining the reasonable cost of services furnished in a cost reporting period, shall be equal to the average of the rates of interest, for each of the months any part of which is included in the period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.[731]

(Q) Except as otherwise explicitly authorized, the Secretary is not authorized to limit the rate of increase on allowable costs of approved medical educational activities.

(R) In determining such reasonable cost, costs incurred by a provider of services representing a beneficiary in an unsuccessful appeal of a determination described in section 1869(b) shall not be allowable as reasonable costs.

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formerly read, see Vol. III, P.L. 101-508.]

See Vol. II, P.L. 101-508, §4027(sic)(d)(2), with respect to updating the wage index, and §4027(sic)(d)(3), with respect to the transition provision for determining the limits of reasonable costs.

[728] P.L. 78-410.

[729] This subparagraph was enacted July 18, 1984.

[730] See Vol. II, P.L. 99-509, §9321(c)(3), with respect to regulations.

[731] See Vol. II, P.L. 99-272, §9115, with respect to information on the impact of prospective payment system payments on hospitals.

(S)(i)[732] Such regulations shall not include provision for specific recognition of any return on equity capital with respect to hospital outpatient departments.

(ii)(I) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of outpatient hospital services, the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1990, by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1991, and by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1992, 1993, 1994, or 1995[733].

(II) The Secretary shall reduce the reasonable cost of outpatient hospital services (other than the capital-related costs of such services) otherwise determined pursuant to section 1833(a)(2)(B)(i)(I) by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991, 1992, 1993, 1994, or 1995.[734]

(III)[735] Subclauses (I) and (II)[736] shall not apply to payments with respect to the costs of hospital outpatient services provided by[737] any hospital that is a sole community hospital (as defined in section 1886(d)(5)(D)(iii) or a rural primary care hospital (as defined in section 1861(mm)(1)[738]).

(IV)[739] In applying subclauses (I) and (II)[740] to services for which payment is made on the basis of a blend amount under section 1833(i)(3)(A)(ii) or 1833(n)(1)(A)(ii), the[741] costs reflected in the amounts described in sections 1833(i)(3)(B)(i)(I) and 1833(n)(1)(B)(i)(I), respectively, shall be reduced in accordance with such subclause.[742]

(2)(A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital[743] extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed the amount that would be taken into account with respect to such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

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[732] P.L. 101-239, §6110(1), inserted "(i)".

[733] P.L. 101-508, §4151(a)(1), inserted ", by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1991, and by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1992, 1993, 1994, or 1995", effective November 5, 1990.

[734] P.L. 101-508, §4151(b)(1)(D), inserted this subclause (II), effective November 5, 1990.

[735] P.L. 101-508, §4151(b)(1)(C), redesignated subclause (II) as subclause (III).

[736] P.L. 101-508, §4151(b)(1)(A)(i), struck out "Subclause (I)" and substituted "Subclauses (I) and (II)", effective November 5, 1990.

[737] P.L. 101-508, §4151(b)(1)(A)(ii), struck out "capital-related costs of" and substituted "costs of hospital outpatient services provided by", effective November 5, 1990.

[738] P.L. 101-508, §4151(a)(2), inserted "or a rural primary care hospital (as defined in section 1861(mm)(1)", effective November 5, 1990.

[739] P.L. 101-508, §4151(b)(1)(C), redesignated subclause (III) as subclause (IV).

[740] P.L. 101-508, §4151(b)(1)(B)(i), struck out "subclause (I)" and substituted "subclauses (I) and (II)", effective November 5, 1990.

[741] P.L. 101-508, §4151(b)(1)(B)(ii), struck out "capital-related" and substituted "the", effective November 5, 1990.

[742] P.L. 101-239, §6110(2), added clause (ii), effective December 19, 1989.

[743] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.

(B) Where a provider of services which has an agreement in effect under this title furnishes to an individual items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under part A or part B, as the case may be, the Secretary shall take into account for purposes of payment to such provider of services only the items or services with respect to which such payment may be made.[744]

(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital[745] extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such bed and board under part A shall be the amount otherwise payable under this title for such bed and board furnished in semi-private accommodations minus the difference between the charge customarily made by the hospital or skilled nursing facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

(4) If a provider of services furnishes items or services to an individual which are in excess of or more expensive than the items or services determined to be necessary in the efficient delivery of needed health services and charges are imposed for such more expensive items or services under the authority granted in section 1866(a)(2)(B)(ii), the amount of payment with respect to such items or services otherwise due such provider in any fiscal period shall be reduced to the extent that such payment plus such charges exceed the cost actually incurred for such items or services in the fiscal period in which such charges are imposed.

(5)(A) Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are furnished under an arrangement with a provider of services or other organization, specified in the first sentence of subsection (p) (including through the operation of subsection (g)) the amount included in any payment to such provider or other organization under this title as the reasonable cost of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement) plus the cost of such other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such therapy) incurred by such person, as the Secretary may in regulations determine to be appropriate.

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[744] See Vol. II, P.L. 97-248, §111, with respect to elimination of private room subsidy.

[745] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.

(B) Notwithstanding the provisions of subparagraph (A), if a provider of services or other organization specified in the first sentence of section 1861(p) requires the services of a therapist on a limited part-time basis, or only to perform intermittent services, the Secretary may make payment on the basis of a reasonable rate per unit of service, even though such rate is greater per unit of time than salary related amounts, where he finds that such greater payment is, in the aggregate, less than the amount that would have been paid if such organization had employed a therapist on a full- or part-time salary basis.

(6) For purposes of this subsection, the term "semi-private accommodations" means two-bed, three-bed, or four-bed accommodations.

(7)(A) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

(B) For further limitations on reasonable cost and determination of payment amounts for operating costs of inpatient hospital services and waivers for certain States, see section 1886.

(C) For provisions restricting payment for provider-based physicians' services and for payments under certain percentage arrangements, see section 1887.

(D) For further limitations on reasonable cost and determination of payment amounts for routine service costs of skilled nursing facilities, see section 1888.

Arrangements for Certain Services

(w)(1) The term "arrangements" is limited to arrangements under which receipt of payment by the hospital, rural primary care hospital,[746] skilled nursing facility, home health agency, or hospice program (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

(2) Utilization review activities conducted, in accordance with the requirements of the program established under part B of title XI of the Social Security Act with respect to services furnished by a hospital or rural primary care hospital[747] to patients insured under part A of this title or entitled to have payment made for such services under part B of this title or under a State plan approved under title XIX, by a quality control and peer review organization designated for the area in which such hospital or rural primary care hospital[748] is located shall be deemed to have been conducted pursuant to arrangements between such hospital or rural primary care hospital[749] and such organization under which such hospital or rural primary care hospital[750] is obligated to pay to such organization, as a

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[746] P.L. 101-239, §6003(g)(3)(D)(x)(II), inserted "rural primary care hospital,", effective December 19, 1989.

[747] P.L. 101-239, §6003(g)(3)(D)(x)(III), inserted "or rural primary care hospital", effective December 19, 1989.

[748] P.L. 101-239, §6003(g)(3)(D)(x)(III), inserted "or rural primary care hospital", effective December 19, 1989.

[749] P.L. 101-239, §6003(g)(3)(D)(x)(III), inserted "or rural primary care hospital", effective December 19, 1989.

[750] P.L. 101-239, §6003(g)(3)(D)(x)(III), inserted "or rural primary care hospital", effective December 19, 1989.

condition of receiving payment for hospital or rural primary care hospital[751] services so furnished under this part or under such a State plan, such amount as is reasonably incurred and requested (as determined under regulations of the Secretary) by such organization in conducting such review activities with respect to services furnished by such hospital or rural primary care hospital[752] to such patients.

State and United States

(x) The terms "State" and "United States" have the meaning given to them by subsections (h) and (i), respectively, of section 210.

Post-Hospital[753] Extended Care in Christian Science Skilled Nursing Facilities

(y)(1) The term "skilled nursing facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only (except for purposes of subsection (a)(2))[754] with respect to items and services ordinarily furnished by such an institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations.

(2) Notwithstanding any other provision of this title, payment under part A may not be made for services furnished an individual in a skilled nursing facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a spell of illness[755] to have such services treated as post-hospital[756] extended care services for purposes of such part; and payment under part A may not be made for post-hospital[757] extended care services—

(A) furnished an individual during such spell of illness[758] in a skilled nursing facility to which paragraph (1) applies after—

(i) such services have been furnished to him in such a facility for 30[759] days during such spell[760], or

(ii) such services have been furnished to him during such spell [761] in a skilled nursing facility to which such paragraph does not apply; or

(B) furnished an individual during such spell of illness[762] in a skilled nursing facility to which paragraph (1) does not apply after such services have been furnished to him during such spell[763] in a skilled nursing facility to which such paragraph applies.

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[751] P.L. 101-239, §6003(g)(3)(D)(x)(III), inserted "or rural primary care hospital", effective December 19, 1989.

[752] P.L. 101-239, §6003(g)(3)(D)(x)(III), inserted "or rural primary care hospital", effective December 19, 1989.

[753] P.L. 101-234, §101(a)(1), inserted "Post-Hospital", effective January 1, 1990.

[754] P.L. 101-234, §101(a)(1), inserted "(except for purposes of subsection (a)(2))", effective January 1, 1990.

[755] P.L. 101-234, §101(a)(1), struck out "year" and substituted "spell of illness" or "spell", effective January 1, 1990.

[756] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.

[757] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.

[758] P.L. 101-234, §101(a)(1), struck out "year" and substituted "spell of illness" or "spell", effective January 1, 1990.

[759] P.L. 101-234, §101(a)(1), struck out "45" and substituted "30", effective January 1, 1990.

[760] P.L. 101-234, §101(a)(1), struck out "year" and substituted "spell of illness" or "spell", effective January 1, 1990.

[761] P.L. 101-234, §101(a)(1), struck out "year" and substituted "spell of illness" or "spell", effective January 1, 1990.

[762] P.L. 101-234, §101(a)(1), struck out "year" and substituted "spell of illness" or "spell", effective January 1, 1990.

(3) The amount payable under part A for post- hospital[764] extended care services furnished an individual during any spell of illness[765] in a skilled nursing facility to which paragraph (1) applies shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day before the 31st[766] day on which he is furnished such services in such a facility during such spell[767] (and the reduction under this paragraph shall be in lieu of any reduction under section 1813(a)(3)).

(4) For purposes of subsection (i), the determination of whether services furnished by or in an institution described in paragraph (1) constitute post-hospital[768] extended care services shall be made in accordance with and subject to such conditions, limitations, and requirements as may be provided in regulations.[769]

Institutional Planning

(z) An overall plan and budget of a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, or home health agency shall be considered sufficient if it—

(1) provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any budget, an item-by-item identification of the components of each type of anticipated expenditure or income);

(2)(A) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in paragraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of $600,000 (or such lesser amount as may be established by the State under section 1122(g)(1) in which the hospital is located) related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

(B) provides that such plan is submitted to the agency designated under section 1122(b), or if no such agency is designated, to the appropriate health planning agency in the State (but this subparagraph shall not apply in the case of a facility exempt from review under section 1122 by reason of section 1122(j));

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[763] P.L. 101-234, §101(a)(1), struck out "year" and substituted "spell of illness" or "spell", effective January 1, 1990.

[764] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.

[765] P.L. 101-234, §101(a)(1), struck out "year" and substituted "spell of illness" or "spell", effective January 1, 1990.

[766] P.L. 101- 234, §101(a)(1), struck out "the coinsurance amount established under section 1813(a)(3)(C) for each day before the 46th", and substituted "one- eighth of the inpatient hospital deductible for each day before the 31st", effective January 1, 1990.

[767] P.L. 101-234, §101(a)(1), struck out "year" and substituted "spell of illness" or "spell", effective January 1, 1990.

[768] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective December 19, 1989.

[769] P.L. 101-234, §101(a)(1), added paragraph (4), effective January 1, 1990.

(3) provides for review and updating at least annually; and

(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the institution or agency.

Rural Health Clinic Services and Federally Qualified Health Center Services[770]

(aa)(1) The term "rural health clinic services" means —

(A) physicians' services and such services and supplies as are covered under section 1861(s)(2)(A) if furnished as an incident to a physician's professional service and items and services described in section 1861(s)(10),

(B) such services furnished by a physician assistant or a nurse practitioner (as defined in paragraph (5)[771]),[772] by a clinical psychologist (as defined by the Secretary) or by a clinical social worker (as defined in subsection (hh)(1)),[773], and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service, and

(C) in the case of a rural health clinic located in an area in which there exists a shortage of home health agencies, part-time or intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan of treatment (i) established and periodically reviewed by a physician described in paragraph (2)(B), or (ii) established by a nurse practitioner or physician assistant and periodically reviewed and approved by a physician described in paragraph (2)(B),

when furnished to an individual as an outpatient of a rural health clinic.

(2) The term "rural health clinic" means a facility which —

(A) is primarily engaged in furnishing to outpatients services described in subparagraphs (A) and (B) of paragraph (1);

(B) in the case of a facility which is not a physician-directed clinic, has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in subsection (r)(1)) under which provision is made for the periodic review by such physicians of covered services furnished by physician assistants and nurse practitioners, the supervision and guidance by such physicians of physician assistants and nurse practitioners, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of and consultation for patients as is necessary and for advice and assistance in the management of medical emergencies; and, in the case of a physician-directed clinic, has one or more of its staff physicians perform the activities accomplished through such an arrangement;

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[770] P.L. 101-508, §4161(a)(2)(A), inserted "and Federally Qualified Health Center Services", applicable to services furnished on or after October 1, 1991.

See Vol. II, P.L. 95-210, §1(e), with respect to private, nonprofit health care clinics.

[771] P.L. 101-508, §4161(a)(5)(B), struck out "(3)" and substituted "(5)", applicable to services furnished on or after October 1, 1991.

[772] P.L. 101-239, §6213(b)(1), struck out "or".

[773] P.L. 101-239, §6213(b)(2), inserted "or by a clinical social worker (as defined in subsection (hh)(1)),", applicable to services furnished on or after*October 1, 1989.

*P.L. 101-239, §6102(e)(11) [as amended by P.L. 101-508, §4027(sic)(m)(4)], in effect, struck out "effective" and substituted "applicable to services furnished on or after".

As in original; one comma should be deleted.

(C) maintains clinical records on all patients;

(D) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

(E) has written policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more physician assistants or nurse practitioners, to govern those services described in paragraph (1) which it furnishes;

(F) has a physician, physician assistant, or nurse practitioner responsible for the execution of policies described in subparagraph (E) and relating to the provision of the clinic's services;

(G) directly provides routine diagnostic services, including clinical laboratory services, as prescribed in regulations by the Secretary, and has prompt access to additional diagnostic services from facilities meeting requirements under this title;

(H) in compliance with State and Federal law, has available for administering to patients of the clinic at least such drugs and biologicals as are determined by the Secretary to be necessary for the treatment of emergency cases (as defined in regulations) and has appropriate procedures or arrangements for storing, administering, and dispensing any drugs and biologicals;

(I) has appropriate procedures for review of utilization of clinic services to the extent that the Secretary determines to be necessary and feasible;[774]

(J) has a nurse practitioner, a physician assistant, or a certified nurse-midwife (as defined in subsection (gg)) available to furnish patient care services not less than 50 percent of the time the clinic operates; and[775]

(K)[776] meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this title, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) and that is designated by the chief executive officer of the State and certified by the Secretary as an area with a shortage of personal health services, or that is designated[777] by the Secretary either (I) as an area with a shortage of personal health services under section 330(b)(3) or 1302(7) of the Public Health Service Act[778], [779] (II) as a health professional[780] shortage area described in section 332(a)(1)(A) of that Act because of its shortage of primary medical care manpower, (III) as a high impact area described in section 329(a)(5) of that Act, of (IV) as an area which includes a population group which the Secretary determines has a health manpower shortage under section 332(a)(1)(B) of that Act,[781] (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1833, (iii) employs a physician assistant or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this title or title XIX and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purposes of this title and title XIX, as still satisfying the requirement of such clause.[782] If a State agency has determined under section 1864(a) that a facility is a rural health clinic and the facility has applied to the Secretary for certification as such a clinic, the Secretary shall notify the facility of the the[783] Secretary's approval or disapproval of the certification not later than 60 days after the date of the State agency determination or the application (whichever is later).[784]

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[774] P.L. 101-239, §6213(a)(1), struck out "and".

[775] P.L. 101-239, §6213(a)(3), added this subparagraph, applicable to services furnished on or after[*] October 1, 1989.

[*] P.L. 101-239, §6102(e)(11) [as amended by P.L. 101-508, §4027(sic)(k)(4)], in effect, struck out "effective" and substituted "applicable to services furnished on or after".

[776] P.L. 101-239, §6213(a)(2), redesignated subparagraph (J) as subparagraph (K), applicable to services furnished on or after[*] October 1, 1989.

[*] P.L. 101-239, §6102(e)(11) [as amended by P.L. 101-508, §4027(sic)(k)(4)], in effect, struck out "effective" and substituted "applicable to services furnished on or after".

(3) The term "Federally qualified health center services" means—

(A) services of the type described in subparagraphs (A) through (C) of paragraph (1), and

(B) preventive primary health services that a center is required to provide under sections 329, 330, and 340 of the Public Health Service Act[785], when furnished to an individual as an outpatient of a Federally qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in paragraph (2)(B) is deemed a reference to a Federally qualified health center or a physician at the center, respectively.[786]

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[777] P.L. 101-239, §6213(c)(1), inserted "by the chief executive officer of the State and certified by the Secretary as an area with a shortage of personal health services, or that is designated", applicable to services furnished on or after* October 1, 1989.

*P.L. 101-239, §6102(e)(11) [as amended by P.L. 101-508, §4027(sic)(k)(4)], in effect, struck out "effective" and substituted "applicable to services furnished on or after".

[778] P.L. 78-410.

[779] P.L. 101-239, §6213(c)(2), struck out "1302(7) of the Public Health Service Act or" and substituted "330(b)(3) or 1302(7) of the Public Health Service Act,", applicable to services furnished on or after* October 1, 1989.

*P.L. 101-239, §6102(e)(11) [as amended by P.L. 101-508, §4027(sic)(k)(4)], in effect, struck out "effective" and substituted "applicable to services furnished on or after".

[780] P.L. 101-597, §401(c)(2), struck out "manpower" and substituted "professional", effective November 16, 1990.

[781] P.L. 101-239, §6213(c)(3), inserted subclauses (III) and (IV), applicable to services furnished on or after* October 1, 1989.

*P.L. 101-239, §6102(e)(11) [as amended by P.L. 101-508, §4027(sic)(k)(4)], in effect, struck out "effective" and substituted "applicable to services furnished on or after".

[782] P.L. 101-239, §6213(f), provides that the Secretary shall not deny certification of a facility as a rural health clinic under this paragraph if the facility is located on an island and would otherwise be qualified to be certified as such a facility but for the requirement that the services of a physician assistant or nurse practitioner be provided in the facility.

[783] As in original; one "the" should be stricken.

[784] P.L. 101-508, §4161(b)(1), added this sentence, effective October 1, 1991.

[785] P.L. 78-410.

(4) The term "Federally qualified health center" means an entity which—

(A)(i) is receiving a grant under section 329, 330, or 340 of the Public Health Service Act, or

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 329, 330, or 340 of such Act;

(B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant; or

(C) was treated by the Secretary, for purposes of part B, as a comprehensive Federally funded health center as of January 1, 1990.[787]

(5)[788] The term "physician assistant", the term "nurse practitioner", and the term "clinical nurse specialist" mean, for purposes of this Act, a physician assistant, nurse practitioner, or clinical nurse specialist[789] who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

(6)[790] The term "collaboration" means a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by the law of the State in which the services are performed.[791]

(7)(A) The Secretary shall waive for a 1-year period the requirements of paragraph (2) that a rural health clinic employ a physician assistant, nurse practitioner or certified nurse midwife or that such clinic require such providers to furnish services at least 50 percent of the time that the clinic operates for any facility that requests such waiver if the facility demonstrates that the facility has been unable, despite reasonable efforts, to hire a physician assistant, nurse practitioner, or certified nurse-midwife in the previous 90-day period.

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[786] P.L. 101-508, §4161(a)(2)(C), inserted this paragraph (3), applicable to services furnished on or after October 1, 1991.

[787] P.L. 101-508, §4161(a)(2)(C), inserted this paragraph (4), applicable to services furnished on or after October 1, 1991.

[788] P.L. 101-508, §4161(a)(2)(B), redesignated paragraph (3) as paragraph (5).

[789] P.L. 101-508, §4155(d), struck out "and the term 'nurse practitioner' mean, for the purposes of paragraphs (1) and (2)*, a physician assistant or nurse practitioner" and substituted ", the term 'nurse practitioner', and the term 'clinical nurse specialist' mean, for purposes of this Act, a physician assistant, nurse practitioner, or clinical nurse specialist", applicable to services furnished on or after January 1, 1991.

*P.L. 101-508, §4161(a)(2)(B), also struck out "paragraphs (1) and (2)" and substituted "the previous provisions of this subsection", applicable to services furnished on or after October 1, 1991. Unable to execute.

[790] P.L. 101-508, §4161(a)(2)(B), redesignated paragraph (4) as paragraph (6).

[791] P.L. 101-239, §6114(d), added paragraph (4), applicable to services furnished on or after April 1, 1990.

(B) The Secretary may not grant such a waiver under subparagraph (A) to a facility if the request for the waiver is made less than 6 months after the date of the expiration of any previous such waiver for the facility.

(C) A waiver which is requested under this paragraph shall be deemed granted unless such request is denied by the Secretary within 60 days after the date such request is received.[792]

Services of a Certified Registered Nurse Anesthetist[793]

(bb)(1) The term "services of a certified registered nurse anesthetist" means anesthesia services and related care furnished by a certified registered nurse anesthetist (as defined in paragraph (2)) which the nurse anesthetist is legally authorized to perform as such by the State in which the services are furnished.

(2) The term "certified registered nurse anesthetist" means a certified registered nurse anesthetist licensed by the State who meets such education, training, and other requirements relating to anesthesia services and related care as the Secretary may prescribe. In prescribing such requirements the Secretary may use the same requirements as those established by a national organization for the certification of nurse anesthetists. Such term also includes, as prescribed by the Secretary, an anesthesiologist assistant.

Comprehensive Outpatient Rehabilitation Facility Services

(cc)(1) The term "comprehensive outpatient rehabilitation facility services" means the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations by the Secretary) to an individual who is an outpatient of a comprehensive outpatient rehabilitation facility under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician—

(A) physicians' services;

(B) physical therapy, occupational therapy, speech pathology services, and respiratory therapy;

(C) prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic and orthotic devices;

(D) social and psychological services;

(E) nursing care provided by or under the supervision of a registered professional nurse;

(F) drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered;

(G) supplies and durable medical equipment; and

(H) such other items and services as are medically necessary for the rehabilitation of the patient and are ordinarily furnished by comprehensive outpatient rehabilitation facilities,

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital. In the case of physical therapy, occupational therapy, and speech pathology services, there shall be no requirement that the item or service be furnished at any single fixed location if the item or service is furnished pursuant to such plan and payments are not otherwise made for the item or service under this title.

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[792] P.L. 101-508, §4161(b)(2), added paragraph (7), effective October 1, 1991.

[793] P.L. 99-509, §9320(c), added subsection (bb). For the effective date, see Vol. II, P.L. 99-509, §9320(i), as amended by P.L. 100-485.

(2) The term "comprehensive outpatient rehabilitation facility" means a facility which—

(A) is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons;

(B) provides at least the following comprehensive outpatient rehabilitation services: (i) physicians' services (rendered by physicians, as defined in section 1861(r)(1), who are available at the facility on a full- or part-time basis); (ii) physical therapy; and (iii) social or psychological services;

(C) maintains clinical records on all patients;

(D) has policies established by a group of professional personnel (associated with the facility), including one or more physicians defined in subsection (r)(1) to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full- or part-time physician referred to in subparagraph (B)(i);

(E) has a requirement that every patient must be under the care of a physician;

(F) in the case of a facility in any State in which State or applicable local law provides for the licensing of facilities of this nature (i) is licensed pursuant to such law, or (ii) is approved by the agency of such State or locality, responsible for licensing facilities of this nature, as meeting the standards established for such licensing;

(G) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(H) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities.

Hospice Care; Hospice Program

(dd)(1) The term "hospice care" means the following items and services provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan (for providing such care to such individual) established and periodically reviewed by the individual's attending physician and by the medical director (and by the interdisciplinary group described in paragraph (2)(B)) of the program—

(A) nursing care provided by or under the supervision of a registered professional nurse,

(B) physical or occupational therapy or speech-language pathology,

(C) medical social services under the direction of a physician,

(D)(i) services of a home health aide who has successfully completed a training program approved by the Secretary and (ii) homemaker services,

(E) medical supplies (including drugs and biologicals) and the use of medical appliances, while under such a plan,

(F) physicians' services,

(G) short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in an inpatient facility meeting such conditions as the Secretary determines to be appropriate to provide such care, but such respite care may be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than five days, and

(H) counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his death.

The care and services described in subparagraphs (A) and (D) may be provided on a 24-hour, continuous basis only during periods of crisis (meeting criteria established by the Secretary) and only as necessary to maintain the terminally ill individual at home.

(2) The term "hospice program" means a public agency or private organization (or a subdivision thereof) which—

(A)(i) is primarily engaged in providing the care and services described in paragraph (1) and makes such services available (as needed) on a 24-hour basis and which also provides bereavement counseling for the immediate family of terminally ill individuals,

(ii) provides for such care and services in individuals' homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the agency or organization, except that—

(I) the agency or organization must routinely provide directly substantially all of each of the services described in subparagraphs (A), (C), (F), and (H) of paragraph (1), except as otherwise provided in paragraph (5),[794] and

(II) in the case of other services described in paragraph (1) which are not provided directly by the agency or organization, the agency or organization must maintain professional management responsibility for all such services furnished to an individual, regardless of the location or facility in which such services are furnished; and

(iii) provides assurances satisfactory to the Secretary that the aggregate number of days of inpatient care described in paragraph (1)(G) provided in any 12-month period to individuals who have an election in effect under section 1812(d) with respect to that agency or organization does not exceed 20 percent[795] of the aggregate number of days during that period on which such elections for such individuals are in effect;

(B) has an interdisciplinary group of personnel which—

(i) includes at least—

(I) one physician (as defined in subsection (r)(1)),

(II) one registered professional nurse, and

(III) one social worker,

employed by the agency or organization, and also includes at least one pastoral or other counselor,

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[794] See Vol. II, P.L. 98-369, §2343(d), with respect to a study and report to Congress on certain "core" services.

[795] P.L. 99-509, §9307(a), provides that, with respect to the Connecticut Hospice, Inc., the reference to "20 percent" is deemed a reference to "50 percent".

(ii) provides (or supervises the provision of) the care and services described in paragraph (1), and

(iii) establishes the policies governing the provision of such care and services;

(C) maintains central clinical records on all patients;

(D) does not discontinue the hospice care it provides with respect to a patient because of the inability of the patient to pay for such care;

(E)(i) utilizes volunteers in its provision of care and services in accordance with standards set by the Secretary, which standards shall ensure a continuing level of effort to utilize such volunteers, and (ii) maintains records on the use of these volunteers and the cost savings and expansion of care and services achieved through the use of these volunteers;

(F) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, is licensed pursuant to such law; and

(G) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization.

(3)(A) An individual is considered to be "terminally ill" if the individual has a medical prognosis that the individual's life expectancy is 6 months or less.

(B) The term "attending physician" means, with respect to an individual, the physician (as defined in subsection (r)(1)), who may be employed by a hospice program, whom the individual identifies as having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care.

(4)(A) An entity which is certified as a provider of services other than a hospice program shall be considered, for purposes of certification as a hospice program, to have met any requirements under paragraph (2) which are also the same requirements for certification as such other type of provider. The Secretary shall coordinate surveys for determining certification under this title so as to provide, to the extent feasible, for simultaneous surveys of an entity which seeks to be certified as a hospice program and as a provider of services of another type.

(B) Any entity which is certified as a hospice program and as a provider of another type shall have separate provider agreements under section 1866 and shall file separate cost reports with respect to costs incurred in providing hospice care and in providing other services and items under this title.

(5)(A) The Secretary may waive the requirements of paragraph (2)(A)(ii)(I) for an agency or organization with respect to all or part of the nursing care described in paragraph (1)(A) if such agency or organization—

(i) is located in an area which is not an urbanized area (as defined by the Bureau of the Census);

(ii) was in operation on or before January 1, 1983; and

(iii) has demonstrated a good faith effort (as determined by the Secretary) to hire a sufficient number of nurses to provide such nursing care directly.

(B) Any waiver, which is in such form and containing such information as the Secretary may require and which is requested by an agency or organization under subparagraph (A), shall be deemed to be granted unless such request is denied by the Secretary within 60 days after the date such request is received by the Secretary. The granting of a waiver under subparagraph (A) shall not preclude the granting of any subsequent waiver request should such a waiver again become necessary.

Discharge Planning Process

(ee)(1) A discharge planning process of a hospital shall be considered sufficient if it is applicable to services furnished by the hospital to individuals entitled to benefits under this title and if it meets the guidelines and standards established by the Secretary under paragraph (2).

(2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care. The guidelines and standards shall include the following:

(A) The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.

(B) Hospitals must provide a discharge planning evaluation for patients identified under subparagraph (A) and for other patients upon the request of the patient, patient's representative, or patient's physician.

(C) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

(D) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services and the availability of those services.

(E) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).

(F) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

(G) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel.

Partial Hospitalization Services

(ff)(1) The term "partial hospitalization services" means the items and services described in paragraph (2) prescribed by a physician and provided under a program described in paragraph (3) under the supervision of a physician pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate staff participating in such program), which plan sets forth the physician's diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan.

(2) The items and services described in this paragraph are—

(A) individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

(B) occupational therapy requiring the skills of a qualified occupational therapist,

(C) services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients,

(D) drugs and biologicals furnished for therapeutic purposes (which cannot, as determined in accordance with regulations, be self-administered),

(E) individualized activity therapies that are not primarily recreational or diversionary,

(F) family counseling (the primary purpose of which is treatment of the individual's condition),

(G) patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment),

(H) diagnostic services, and

(I) such other items and services as the Secretary may provide (but in no event to include meals and transportation);

that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary shall by regulation establish (taking into account accepted norms of medical practice and the reasonable expectation of patient improvement).

(3)(A)[796] A program described in this paragraph is a program which is furnished by a hospital to its outpatients or by a community mental health center (as defined in subparagraph (B)),[797] and which is a distinct and organized intensive ambulatory treatment service offering less than 24-hour-daily care.

(B) For purposes of subparagraph (A), the term "community mental health center" means an entity—

(i) providing the services described in section 1916(c)(4) of the Public Health Service Act[798]; and

(ii) meeting applicable licensing or certification requirements for community mental health centers in the State in which it is located.[799]

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[796] P.L. 101-508, §4162(a)(1), redesignated paragraph (3) as subparagraph (A).

[797] P.L. 101-508, §4162(a)(2), inserted "or by a community mental health center (as defined in subparagraph (B)),", applicable to partial hospitalization services provided on or after October 1, 1991.

[798] P.L 78-410.

[799] P.L. 101-508, §4162(a)(3), added subparagraph (B), applicable to partial hospitalization services provided on or after October 1, 1991.

Certified Nurse-Midwife Services

(gg)(1) The term "certified nurse-midwife services" means such services furnished by a certified nurse-midwife (as defined in paragraph (2)) and such services and supplies furnished as an incident to the nurse-midwife's service which the certified nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician or as an incident to a physicians' service.

(2) The term "certified nurse-midwife" means a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified by an organization recognized by the Secretary, and performs services in the area of management of the care of mothers and babies throughout the maternity cycle.

Clinical Social Worker; Clinical Social Worker Services[800]

(hh)(1)[801] The term "clinical social worker" means an individual who—

(A)[802] possesses a master's or doctor's degree in social work;

(B)[803] after obtaining such degree has performed at least 2 years of supervised clinical social work; and

(C)[804](i)[805] is licensed or certified as a clinical social worker by the State in which the services are performed, or

(ii)[806] in the case of an individual in a State which does not provide for licensure or certification—

(I)[807] has completed at least 2 years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting (as determined by the Secretary), and

(II)[808] meets such other criteria as the Secretary establishes.

(2) The term "clinical social worker services" means services performed by a clinical social worker (as defined in paragraph (1)) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation) which the clinical social worker is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.[809]

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[800] P.L. 101-239, §6113(b)(2)(B)(i), added "; Clinical Social Worker Services", applicable to services furnished on or after July 1, 1990.

[801] P.L. 101-239, §6113(b)(2)(B)(v), inserted "(1)".

[802] P.L. 101-239, §6113(b)(2)(B)(iv), redesignated paragraphs (1), (2), and (3) as subparagraphs (A), (B), and (C).

[803] P.L. 101-239, §6113(b)(2)(B)(iv), redesignated paragraphs (1), (2), and (3) as subparagraphs (A), (B), and (C).

[804] P.L. 101-239, §6113(b)(2)(B)(iv), redesignated paragraphs (1), (2), and (3) as subparagraphs (A), (B), and (C).

[805] P.L. 101-239, §6113(b)(2)(B)(iii), redesignated subparagraphs (A) and (B) as clauses (i) and (ii).

[806] P.L. 101-239, §6113(b)(2)(B)(iii), redesignated subparagraphs (A) and (B) as clauses (i) and (ii).

[807] P.L. 101-239, §6113(b)(2)(B)(ii), redesignated clauses (i) and (ii) as subclauses (I) and (II).

[808] P.L. 101-239, §6113(b)(2)(B)(ii), redesignated clauses (i) and (ii) as subclauses (I) and (II).

[809] P.L. 101-239, §6113(b)(2)(B)(vi), added this paragraph, applicable to services furnished on or after July 1, 1990.

Qualified Psychologist Services

(ii) The term "qualified psychologist services" means such services and such services and supplies furnished as an incident to his service furnished by a clinical psychologist (as defined by the Secretary)[810] which the psychologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician or as an incident to a physician's service.

Covered Osteoporosis Drug[811]

(jj) The term "covered osteoporosis drug" means an injectable drug approved for the treatment of a bone fracture related to post-menopausal osteoporosis provided to an individual if, in accordance with regulations promulgated by the Secretary—

(1) the individual's attending physician certifies that the patient is unable to learn the skills needed to self-administer such drug or is otherwise physically or mentally incapable of self-administering such drug; and

(2) the individual is confined to the individual's home (except when receiving items and services referred to in subsection (m)(7)).

Screening Mammography[812]

(jj) The term "screening mammography" means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure.

[(kk) Repealed.[813]]

[(ll) Repealed.[814]]

Rural Primary Care Hospital; Rural Primary Care Hospital Services[815]

(mm)(1) The term "rural primary care hospital" means a facility designated by the Secretary as a rural primary care hospital under section 1820(i)(2).

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[810] P.L. 101-239, §6113(a), struck out "on-site at a community mental health center (as such term is used in the Public Health Service Act), and such services that are necessarily furnished off-site (other than at an off-site office of such psychologist) as part of a treatment plan because of the inability of the individual furnished such services to travel to the center by reason of physical or mental impairment, because of institutionalization, or because of similar circumstances of the individual,", applicable to services furnished on or after July 1, 1990.

[811] P.L. 100-360, §203(b), added subsection (jj), applicable to items and services furnished on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed subsection (jj), effective January 1, 1990. [For subsection (jj) as it formerly read, see Vol. III, P.L. 101-234.]

P.L. 101-508, §4156(a)(2), added this subsection (jj), effective November 5, 1990.

[812] P.L. 101-508, §4163(a)(2), added this second subsection (jj), applicable to screening mammography performed on or after January 1, 1991.

Possibly should be subsection (kk).

[813] P.L. 100-360, §204(a)(2), added subsection (kk), applicable to screening mammography performed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed subsection (kk), effective January 1, 1990. [For subsection (kk) as it formerly read, see Vol. III, P.L. 101-234.]

[814] P.L. 100-360, §205(b), added subsection (ll), applicable to items and services furnished on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed subsection (ll), effective January 1, 1990. [For subsection (ll) as it formerly read, see Vol. III, P.L. 101-234.]

P.L. 100-360, §205(g), with respect to a study of alternative out-of-home services, was repealed, effective January 1, 1990.

[815] P.L. 101-239, §6003(g)(3)(A), added subsection (mm), effective December 19, 1989.

(2) The term "inpatient rural primary care hospital services" means items and services, furnished to an inpatient of a rural primary care hospital by such a hospital, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.

(3) The term "outpatient rural primary care hospital services" means medical and other health services furnished by a rural primary care hospital.[816]

Screening Pap Smear[817]

(nn) The term "screening pap smear" means a diagnostic laboratory test consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the purpose of early detection of cervical cancer and includes a physician's interpretation of the results of the test, if the individual involved has not had such a test during the preceding 3 years (or such shorter period as the Secretary may specify in the case of a woman who is at high risk of developing cervical cancer (as determined pursuant to factors identified by the Secretary)).

EXCLUSIONS FROM COVERAGE AND MEDICARE AS SECONDARY PAYER[818]

Sec. 1862. [42 U.S.C. 1395y] (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) which, except for items and services described in a succeeding subparagraph[819], are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,[820]

(B) in the case of items and services described in section 1861(s)(10), which are not reasonable and necessary for the prevention of illness,

(C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness,[821]

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the Prospective Payment Assessment Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1886(e)(6),[822]

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[816] P.L. 101-239, §6116(a)(1), added paragraph (3), effective December 19, 1989.

[817] P.L. 101-239, §6115(a)(2), added subsection (nn), applicable to screening pap smears performed on or after July 1, 1990.

[818] P.L. 101-239, §6202(b)(1)(A), added "AND MEDICARE AS SECONDARY PAYER", applicable to items and services furnished after December 19, 1989.

See Vol. II, P.L. 98-21, §601(a)(3), with respect to rules implementing §1886(c).

See Vol. II, P.L. 98-369, §2325, with respect to payment for debridement of mycotic toenails.

[819] P.L. 100-360, §204(d)(2)(A)(i), struck out "subparagraph (B), (C), (D), or (E)" and substituted "a succeeding subparagraph", applicable to screening mammography performed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "a succeeding subparagraph" and substituted "subparagraph (B), (C), (D), or (E)", effective January 1, 1990.

P.L. 101-508, §4163(d)(2)(A)(i), struck out "subparagraph (B), (C), (D), or (E)" and substituted "a succeeding subparagraph", applicable to screening mammography performed on or after January 1, 1991.

[820] See Vol. II, P.L. 99-272, §§9126(c) and 9205, with respect to the waiver of liability presumptions pertaining to skilled nursing facilities and home health agencies, respectively.

See Vol. II, P.L. 100-203, §4009(b), with respect to the designation of pediatric hospitals as meeting certification as heart transplant facility.

[821] See Vol. II, P.L. 99-509, §9305(f), with respect to extending the waiver of liability provisions to hospice programs.

(E) in the case of research conducted pursuant to section 1142[823], which is not reasonable and necessary to carry out the purposes of that section, and[824]

(F) in the case of screening mammography, which is performed more frequently than is covered under section 1834(c)(2) or which does not meet the standards established under section 1834(c)(3), and, in the case of screening pap smear, which is performed more frequently than is provided under section 1861(nn);[825]

[(G) Repealed.[826]]

(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for, except in the case of Federally qualified health center services[827];

(3) which are paid for directly or indirectly by a governmental entity (other than under this Act and other than under a health benefits or insurance plan established for employees of such an entity), except in the case of rural health clinic services, as defined in section 1861(aa)(1),[828], in the case of Federally qualified health center services, as defined in section 1861(aa)(3),[829] and in such other cases as the Secretary may specify;

(4) which are not provided within the United States (except for inpatient hospital services furnished outside the United States under the conditions described in section 1814(f) and, subject to such conditions, limitations, and requirements as are provided under or pursuant to this title, physicians' services and ambulance services furnished an individual in conjunction with such inpatient hospital services but only for the period during which such inpatient hospital services were furnished);

(5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part;

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[822] P.L. 101-234, §201(a)(1), added "and".

P.L. 101-508, §4163(d)(2)(A)(ii), struck out "and".

[823] P.L. 101-239, §6103(b)(3)(B), struck out "1875(c)" and substituted "1142", effective December 19, 1989.

[824] P.L. 100-360, §204(d)(2)(A)(iii), struck out a semicolon and substituted ", and".

P.L. 100-360, §205(e)(1)(A)(i), struck out "and".

P.L. 101-234, §201(a)(1), repealed P.L. 100-360, §§204 and 205. Executed as if §205 was repealed before §204.

P.L. 101-508, §4163(d)(2)(A)(iii), struck out a semicolon and substituted ", and".

[825] P.L. 100-360, §204(d)(2)(A)(iv), added subparagraph (F), applicable to screening mammography performed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed subparagraph (F), effective January 1, 1990. [For subparagraph (F) as it formerly read, see Vol. III, P.L. 101-234.]

P.L. 101-239, §6115(b), amended subparagraph (F), by inserting ", and, in the case of screening pap smear, which is performed more frequently than is provided under * 1861(nn)", applicable to screening pap smears performed on or after July 1, 1990. Impossible to execute.

*Probably should read "under section".

P.L. 101-508, §4163(d)(2)(A)(iv), added this subparagraph (F), applicable to screening mammography performed on or after January 1, 1991.

[826] P.L. 100-360, §205(e)(1)(A)(iii) [as redesignated by P.L. 100-485, §608(d)(7)], added subparagraph (G), applicable to items and services furnished on or after January 1, 1990.

P.L. 101-234, §201(a)(1), repealed subparagraph (G), effective January 1, 1990. [For subparagraph (G) as it formerly read, see Vol. III, P.L. 101-234.]

[827] P.L. 101-508, §4161(a)(3)(C)(i), inserted ", except in the case of Federally qualified health center services", applicable to services furnished on or after October 1, 1991.

[828] As in original; one comma should be stricken.

[829] P.L. 101-508, §4161(a)(3)(C)(ii), inserted ", in the case of Federally qualified health center services, as defined in section 1861(aa)(3),", applicable to services furnished on or after October 1, 1991.

(6) which constitute personal comfort items (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C)[830]);

(7) where such expenses are for routine physical checkups, eyeglasses (other than eyewear described in section 1861(s)(8))[831] or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations (except as otherwise allowed under section 1861(s)(10) and paragraph (1)(B) or under paragraph (1)(F)[832]);

(8) where such expenses are for orthopedic shoes or other supportive devices for the feet, other than shoes furnished pursuant to section 1861(s)(12)[833];

(9) where such expenses are for custodial care (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C));

(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

(11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household;

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services;

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supportive devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care);

(14) which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by section 1861(s)(2)(K)(i), certified nurse-midwife services, qualified psychologist services, and serv-

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[830] P.L. 100-360, §205(e)(1)(B), inserted "and except, in the case of in-home care, as is otherwise permitted under paragraph (1)(G)", applicable to items and services furnished on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "and except, in the case of in-home care, as is otherwise permitted under paragraph (1)(G)", effective January 1, 1990.

[831] P.L. 101-508, §4153(b)(2)(B), inserted "(other than eyewear described in section 1861(s)(8))", applicable to items furnished on or after January 1, 1991.

[832] P.L. 100-360, §204(d)(2)(B), inserted "or under paragraph (1)(F)", applicable to screening mammography performed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "or under paragraph (1)(F)", effective January 1, 1990.

P.L. 101-508, §4163(d)(2)(B), inserted "or under paragraph (1)(F)", applicable to screening mammography performed on or after January 1, 1991.

[833] P.L. 100-203, §4072(c), inserted ", other than shoes furnished pursuant to section 1861(s)(12)". For the effective date, see Vol. II, P.L. 100-203, §4072(e).

ices of a certified registered nurse anesthetist,[834] and which are furnished to an individual who is a patient of a hospital or rural primary care hospital[835] by an entity other than the hospital or rural primary care hospital[836], unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the hospital or rural primary care hospital[837] [838],[839]

(15)(A)[840] which are for services of an assistant at surgery in a cataract operation (including subsequent insertion of an intraocular lens) unless, before the surgery is performed, the appropriate utilization and quality control peer review organization (under part B of title XI) or a carrier under section 1842 has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition, or[841]

(B) which are for services of an assistant at surgery to which section 1848(i)(2)(B) applies; or[842]

(16) furnished in connection with a surgical procedure for which a second opinion is required under section 1164(c)(2) and has not been obtained.

Paragraph (7) shall not apply to Federally qualified health center services described in section 1861(aa)(3)(B).[843]

(b) MEDICARE AS SECONDARY PAYER.—

(1) REQUIREMENTS OF GROUP HEALTH PLANS.—

(A) WORKING AGED UNDER GROUP HEALTH PLANS.—

(i) IN GENERAL.—A group health plan—

(I) may not take into account, for any item or service furnished to an individual 65 years of age or older at the time the individual is covered under the plan by reason of the current employment of the individual (or the individual's spouse), that the individual is entitled to benefits under this title under section 226(a), and

(II) shall provide that any employee age 65 or older, and any employee's spouse age 65 or older, shall be entitled to the same benefits under the plan under the same conditions as any employee, and the spouse of such employee, under age 65.

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[834] P.L. 101-508, §4157(c)(1)(B), inserted ", services described by section 1861(s)(2)(K)(i), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist,", applicable to services furnished on or after January 1, 1991.

[835] P.L. 101-239, §6003(g)(3)(D)(xi), inserted "or rural primary care hospital", effective December 19, 1989.

[836] P.L. 101-239, §6003(g)(3)(D)(xi), inserted "or rural primary care hospital", effective December 19, 1989.

[837] P.L. 101-239, §6003(g)(3)(D)(xi), inserted "or rural primary care hospital", effective December 19, 1989.

[838] P.L. 99-509, §9320(h)(1) [as amended by P.L. 100-203, §4009(j)(6)(C)], inserted "or are services of a certified registered nurse anesthetist". For the effective date, see Vol. II, P.L. 99-509, §9320(i), as amended by P.L. 100-485.

P.L. 101-508, §4157(c)(1)(A), struck out "or are services of a certified registered nurse anesthetist", applicable to services furnished on or after January 1, 1991.

[839] See Vol. II, P.L. 98-21, §602(k), with respect to certain conditions under which the Secretary may waive the requirements of this provision.

[840] P.L. 101-508, §4107(b)(1), redesignated paragraph (15) as subparagraph (A).

[841] P.L. 101-508, §4107(b)(2), struck out "; or" and substituted ", or".

See Vol. II, P.L. 99-514, §1895(b)(16)(C), with respect to deeming approval.

[842] P.L. 101-508, §4107(b)(3), added subparagraph (B), applicable to services furnished on or after January 1, 1992.

[843] P.L. 101-508, §4161(a)(3)(C)(iii), added this sentence, applicable to services furnished on or after October 1, 1991.

(ii) EXCLUSION OF GROUP HEALTH PLAN OF A SMALL EMPLOYER.—Clause (i) shall not apply to a group health plan unless the plan is sponsored by or contributed to by an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.[844]

(iii) EXCEPTION FOR SMALL EMPLOYERS IN MULTI-EMPLOYER OR MULTIPLE EMPLOYER GROUP HEALTH PLANS.—Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multiple employer group health plan if the coverage of the individuals under the plan is by virtue of employment with an employer that does not have 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.[845]

(iv) EXCEPTION FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.—Clause (i) shall not apply to an item or service furnished in a month to an individual if for the month the individual is, or would upon application be, entitled to benefits under section 226A.[846]

(v) GROUP HEALTH PLAN DEFINED.—In this subparagraph, and subparagraph (C), the term "group health plan" has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986.[847]

(B) DISABLED ACTIVE INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(i) IN GENERAL.—A large group health plan (as defined in clause (iv)(II)) may not take into account that an active individual (as defined in clause (iv)(I)) is entitled to benefits under this title under section 226(b).

(ii) EXCEPTION FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.—Clause (i) shall not apply to an item or service furnished in a month to an individual if for the month the individual is, or would upon application be, entitled to benefits under section 226A.

(iii) SUNSET.—Clause (i) shall only apply to items and services furnished on or after January 1, 1987, and before October 1, 1995[848].

(iv) DEFINITIONS.—In this subparagraph:

(I) ACTIVE INDIVIDUAL.—The term "active individual" means an employee (as may be defined in regulations), the employer, self-employed individual

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[844] Alinement as in original.
[845] Alinement as in original.
[846] Alinement as in original.
[847] Alinement as in original.
[848] P.L. 101-508, §4203(b), struck out "January 1, 1992" and substituted "October 1, 1995", effective November 5, 1990.

(such as the employer), an individual associated with the employer in a business relationship, or a member of the family of any of such persons.

(II) LARGE GROUP HEALTH PLANS.—The term "large group health plan" has the meaning given such term in section 5000(b)(2) of the Internal Revenue Code of 1986.

(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—A group health plan (as defined in subparagraph (A)(v))—

(i) may not take into account that an individual is entitled to benefits under this title solely by reason of section 226A during the 12-month period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 226A, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 226A if the individual had filed an application for such benefits; and[849]

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from taking into account that an individual is entitled to benefits under this title solely by reason of section 226A after the end of the 12-month period described in clause (i). Effective for items and services furnished on or after February 1, 1991, and on or before January 1, 1996, (with respect to periods beginning on or after February 1, 1990), clauses (i) and (ii) shall be applied by substituting "18-month" for "12-month" each place it appears.[850]

(D) TREATMENT OF CERTAIN MEMBERS OF RELIGIOUS ORDERS.—In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious order which are considered employment only by virtue of an election made by the religious order under section 3121(r) of the Internal Revenue Code of 1986.[851]

(2) MEDICARE SECONDARY PAYER.—

(A) IN GENERAL.—Payment under this title may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that—

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[849] P.L. 101-508, §4203(c)(1)(A), struck out "earlier of—" and clauses (I) and (II) and substituted "first month in which the individual becomes entitled to benefits under part A under the provisions of section 226A, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 226A if the individual had filed an application for such benefits; and", effective November 5, 1990. [For clauses (I) and (II) as they formerly read, see Vol. III, P.L. 101-508.]

[850] P.L. 101-508, §4203(c)(1)(B), added this sentence, effective November 5, 1990.

See Vol. II, P.L. 101-508, §4203(c)(2), with respect to the GAO study of extension of secondary payer period.

[851] P.L. 101-239, §6202(e)(1), added subparagraph (D), applicable to items and services furnished on or after October 1, 1989.

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In the subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies.

(B) CONDITIONAL PAYMENT.—

(i) PRIMARY PLANS.—Any payment under this title with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been or could be made under such subparagraph.

(ii) ACTION BY UNITED STATES.—In order to recover payment under this title for such an item or service, the United States may bring an action against any entity which is required or responsible under this subsection to pay with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service.

(iii) SUBROGATION RIGHTS.—The United States shall be subrogated (to the extent of payment made under this title for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(iv) WAIVER OF RIGHTS.—The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this title.

(3) ENFORCEMENT.—

(A) PRIVATE CAUSE OF ACTION.—There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with such paragraphs (1) and (2)(A)[852].

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[852] As in original.

(B) Reference to excise tax with respect to nonconforming group health plans.—For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of the Internal Revenue Code of 1986.

(C) Prohibition of financial incentives not to enroll in a group health plan.—It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under this title not to enroll (or to terminate enrollment) under a group health plan which would (in the case of such enrollment) be a primary plan (as defined in paragraph (2)(A)), unless such incentive is also offered to all individuals who are eligible for coverage under the plan. Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed $5,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).[853]

(4) Coordination of benefits.—Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this title (without regard to deductibles and coinsurance under this title) for the remainder of such charge, but—

(A) payment under this title may not exceed an amount which would be payable under this title for such item or service if paragraph (2)(A) did not apply; and

(B) payment under this title, when combined with the amount payable under the primary plan, may not exceed—

(i) in the case of an item or service payment for which is determined under this title on the basis of reasonable cost (or other cost-related basis) or under section 1886, the amount which would be payable under this title on such basis, and

(ii) in the case of an item or service for which payment is authorized under this title on another basis—

(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

(II) the reasonable charge or other amount which would be payable under this title (without regard to deductibles and coinsurance under this title),

whichever is greater.[854]

(5) Identification of secondary payer situations.—

(A) Requesting matching information.—

(i) Commissioner of social security.—The Commissioner of Social Security shall, not less often that annually, transmit to the Secretary of the Treasury a list of the names and TINs of medicare beneficiaries (as defined in section 6103(l)(12) of the Internal Revenue Code of 1986) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.[855]

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[853] P.L. 101-508, §4204(g)(1), added subparagraph (C), applicable to incentives offered on or after November 5, 1990.

[854] P.L. 101-239, §6202(b)(1)(B), amended subsection (b) in its entirety, applicable to items and services furnished after December 19, 1989. [For subsection (b) as it formerly read, see Vol. III, P.L. 101-239.]

(ii) ADMINISTRATOR.—The Administrator of the Health Care Financing Administration shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(l)(12) of the Internal Revenue Code of 1986.

(B) DISCLOSURE TO FISCAL INTERMEDIARIES AND CARRIERS.—In addition to any other information provided under this title to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for the purposes of carrying out this subsection.

(C) CONTACTING EMPLOYERS.—

(i) IN GENERAL.—With respect to each individual (in this subparagraph referred to as an "employee") who was furnished a written statement under section 6051 of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(l)(12)(D)(iii) of such Code), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

(ii) EMPLOYER RESPONSE.—Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provision of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(iii) SUNSET ON REQUIREMENT.—Clause (ii) shall not apply to inquiries made after September 30, 1995[856].[857]

(c)[858] No payment may be made under part B for any expenses incurred for—

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[855] P.L. 101-239, §6202(a)(2)(B), requires that the Commissioner of Social Security first (i) transmit to the Secretary of the Treasury information under this clause and (ii) request from the Secretary disclosure of information described in section 6013(l)(12)(A) of the Internal Revenue Code of 1986, by not later than January 2, 1990.

[856] P.L. 101-508, §4203(a)(1), struck out "1991" and substituted "1995", effective November 5, 1990.

[857] P.L. 101-239, §6202(a)(2)(A), added paragraph (5), effective December 19, 1989.

[858] P.L. 101-234, §201(a)(1), struck out "(1)".

(1)[859] a drug product—

(A)[860] which is described in section 107(c)(3) of the Drug Amendments of 1962[861],

(B)[862] which may be dispensed only upon prescription,

(C)[863] for which the Secretary has issued a notice of an opportunity for a hearing under subsection (e) of section 505 of the Federal Food, Drug, and Cosmetic Act[864] on a proposed order of the Secretary to withdraw approval of an application for such drug product under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling, and

(D)[865] for which the Secretary has not determined there is a compelling justification for its medical need; and

(2)[866] any other drug product—

(A)[867] which is identical, related, or similar (as determined in accordance with section 310.6 of title 21 of the Code of Federal Regulations) to a drug product described in paragraph (1)[868], and

(B)[869] for which the Secretary has not determined there is a compelling justification for its medical need,

until such time as the Secretary withdraws such proposed order.

[(d) Repealed.[870]]

(e)(1) No payment may be made under this title with respect to any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital[871]) furnished—

(A) by an individual or entity during the period when such individual or entity is excluded pursuant to section 1128, 1128A, 1156 or 1842(j)(2) from participation in the program under this title; or

(B) at the medical direction or on the prescription of a physician during the period when he is excluded pursuant to section 1128, 1128A, 1156 or 1842(j)(2)[872] from participation in the program under this title and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

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[859] P.L. 101-234, §201(a)(1), redesignated subparagraph (A) as paragraph (1).

[860] P.L. 101-234, §201(a)(1), redesignated clause (i) as subparagraph (A).

[861] P.L. 87-781.

[862] P.L. 101-234, §201(a)(1), redesignated clause (ii) as subparagraph (B).

[863] P.L. 101-234, §201(a)(1), redesignated clause (iii) as subparagraph (C).

[864] P.L. 75-717.

[865] P.L. 101-234, §201(a)(1), redesignated clause (iv) as subparagraph (D).

[866] P.L. 100-360, §202(d)(6), added paragraph (2), applicable to items dispensed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), redesignated subparagraph (B) as paragraph (2).

P.L. 101-234, §201(a)(1), repealed paragraph (2), effective January 1, 1990. [For paragraph (2) as it formerly read, see Vol. III, P.L. 101-234.]

See Vol. II, P.L. 97-248, §115(b), with respect to use of funds for implementing or enforcing this subsection.

[867] P.L. 101-234, §201(a)(1), redesignated clause (i) as subparagraph (A).

[868] P.L. 100-360, §202(d)(2), struck out "paragraph (1)" and substituted "subparagraph (A)", applicable to items dispensed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "subparagraph (A)" and substituted "paragraph (1)", effective January 1, 1990.

[869] P.L. 101-234, §201(a)(1), redesignated clause (ii) as subparagraph (B).

[870] P.L. 100-93, §8(c)(1)(A), 101 Stat. 692.

[871] P.L. 101-239, §6411(d)(2), inserted ", not including items or services furnished in an emergency room of a hospital", effective December 19, 1989.

[872] P.L. 100-360, §411(i)(4)(D)(i)(I) [as amended by P.L. 100-485, §608(d)(24)(C)(i)], struck out "or section 1128A" and substituted ", 1128A, 1156 or 1842(j)(2)", effective July 1, 1988.

(2) Where an individual eligible for benefits under this title submits a claim for payment for items or services furnished by an individual or entity excluded from participation in the programs under this title, pursuant to section 1128, 1128A, 1156, 1160 (as in effect on September 2, 1982), 1842(j)(2), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987[873]), or 1866, and such beneficiary did not know or have reason to know that such individual or entity was so excluded, then, to the extent permitted by this title, and notwithstanding such exclusion, payment shall be made for such items or services. In each such case the Secretary shall notify the beneficiary of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an excluded individual or entity to a beneficiary after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the beneficiary of the exclusion of that individual or entity.

(f) The Secretary shall establish utilization guidelines for the determination of whether or not payment may be made, consistent with paragraph (1)(A) of subsection (a), under part A or part B for expenses incurred with respect to the provision of home health services, and shall provide for the implementation of such guidelines through a process of selective postpayment coverage review by intermediaries or otherwise.

(g) The Secretary shall, in making the determinations under paragraphs (1) and (9) of subsection (a), and for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services of the type for which payment may be made under this title, enter into contracts with utilization and quality control peer review organizations pursuant to part B of title XI of this Act.

(h)(1)(A) The Secretary shall, through the Commissioner of the Food and Drug Administration, provide for a registry of all cardiac pacemaker devices and pacemaker leads for which payment was made under this title.

(B) Such registry shall include the manufacturer, model, and serial number of each such device or lead, the name of the recipient of such device or lead, the date and location of the implantation or removal of the device or lead, the name of the physician implanting or removing such device or lead, the name of the hospital or other provider billing for such procedure, any express or implied warranties associated with such device or lead under contract or State law (and any amount paid to a provider under any such warranty), and such other information as the Secretary deems to be appropriate.

(C) Each physician and provider of services performing the implantation or replacement of pacemaker devices and leads for which payment is made or requested to be made under this title shall, in accordance with regulations of the Secretary, submit information respecting such implantation or replacement for the registry.

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[873] P.L. 100-93, approved August 18, 1987.

(D) Such registry shall be for the purposes of assisting the Secretary in determining when payments may properly be made under this title, in tracing the performance of cardiac pacemaker devices and leads, in determining when inspection by the manufacturer of such a device or lead may be necessary under paragraph (3), in determining the amount subject to repayment under paragraph (2)(C), and in carrying out studies with respect to the use of such devices and leads. In carrying out any such study, the Secretary may not reveal any specific information which identifies any pacemaker device or lead recipient by name (or which would otherwise identify a specific recipient).

(E) Any person or organization may provide information to the registry with respect to cardiac pacemaker devices and leads other than those for which payment is made under this title.

(2) The Secretary may, by regulation, require each provider of services—

(A) to return, to the manufacturer of the device or lead for testing under paragraph (3), any cardiac pacemaker device or lead which is removed from a patient and payment for the implantation or replacement of which was made or requested by such provider under this title,

(B) not to charge any beneficiary for replacement of such a device or lead if the device or lead has not been returned in accordance with subparagraph (A), and

(C) to make repayment to the Secretary of amounts paid under this title to the provider with respect to any cardiac pacemaker device or lead which has been replaced by the manufacturer, or for which the manufacturer has made payment to the provider, under an express or implied warranty.

(3) The Secretary may, by regulation, require the manufacturer of a cardiac pacemaker device or lead (A) to test or analyze each pacemaker device or lead for which payment is made or requested under this title and which is returned to the manufacturer by a provider of services under paragraph (2), and (B) to provide the results of such test or analysis to that provider, together with information and documentation with respect to any warranties covering such device or lead. In any case where the Secretary has reason to believe, based upon information in the pacemaker registry or otherwise available to him, that replacement of a cardiac pacemaker device or lead for which payment is or may be requested under this title is related to the malfunction of a device or lead, the Secretary may require that personnel of the Food and Drug Administration be present at the testing of such device by the manufacturer, to determine whether such device was functioning properly.

(4) The Secretary may deny payment under this title, in whole or in part and for such period of time as the Secretary determines to be appropriate, with respect to the implantation or replacement of a pacemaker device or lead of a manufacturer performed by a physician and provider of services after the Secretary determines (in accordance with the procedures established under subsections (c), (f), and (g) of section 1128) that—

(A) the physician or provider of services has failed to submit information to the registry as required under paragraph (1)(C),

(B) the provider of services has failed to return devices and leads as required under paragraph (2)(A), has improperly charged beneficiaries as prohibited under paragraph (2)(B), or has failed to make repayment to the Secretary as required under paragraph (2)(C), or

(C) the manufacturer of the device or lead has failed to perform and to report on the testing of devices and leads returned to it as required under paragraph (3).

(i) In order to supplement the activities of the Prospective Payment Assessment Commission under section 1886(e) in assessing the safety, efficacy, and cost-effectiveness of new and existing medical procedures, the Secretary may carry out, or award grants or contracts for, original research and experimentation of the type described in clause (ii) of section 1886(e)(6)(E) with respect to such a procedure if the Secretary finds that—

(1) such procedure is not of sufficient commercial value to justify research and experimentation by a commerical organization;

(2) research and experimentation with respect to such procedure is not of a type that may appropriately be carried out by an institute, division, or bureau of the National Institutes of Health; and

(3) such procedure has the potential to be more cost-effective in the treatment of a condition than procedures currently in use with respect to such condition.

CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION FOR PROVIDERS OF SERVICES

SEC. 1863. [42 U.S.C. 1395z] In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections (e)(9), (f)(4), (j)(15), (o)(6), (cc)(2)(I), and (dd)(2)[874] of section 1861, or by ambulatory surgical centers under section 1832(a)(2)(F)(i), or whether screening mammography meets the standards established under section 1834(c)(3),[875] the Secretary shall consult with appropriate State agencies and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. Such conditions prescribed under any of such subsections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide higher requirements for such State than for other States; except that, in the case of any State or political subdivision of a State which imposes higher requirements on institutions as a condition to the purchase of services (or of certain specified services) in such institutions under a

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[874] P.L. 100-360, §203(e)(2), struck out "and (dd)(2)" and substituted "(dd)(2), and (jj)(3)", applicable to items and services furnished on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "(dd)(2), and (jj)(3)" and substituted "and (dd)(2)", effective January 1, 1990.

P.L. 101-239, §6003(g)(3)(C)(ii), struck out "and (jj)(3)" and substituted "(jj)(3), and (mm)(1)", effective December 19, 1989. Impossible to execute.

[875] P.L. 100-360, §204(c)(1), inserted "or whether screening mammography meets the standards established under section 1834(e)(3),", applicable to screening mammography performed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "or whether screening mammography meets the standards established under section 1834(e)(3),", effective January 1, 1990.

P.L. 101-508, §4163(c)(1), inserted "or whether screening mammography meets the standards established under section 1834(c)(3),", applicable to screening mammography performed on or after January 1, 1991.

State plan approved under title I, XVI, or XIX, the Secretary shall impose like requirements as a condition to the payment for services (or for the services specified by the State or subdivision) in such institutions in such State or subdivision.

USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION[876]

SEC. 1864. [42 U.S.C. 1395aa] (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether an agency is a hospice program[877] or whether a facility therein is a rural health clinic as defined in section 1861(aa)(2), a rural primary care hospital, as defined in section 1861(mm)(1),[878] or a comprehensive outpatient rehabilitation facility as defined in section 1861(cc)(2), or whether a laboratory meets the requirements of paragraphs (15) and (16)[879] of section 1861(s) or (in the case of a laboratory that does not participate or seek to participate in the medicare program) the requirements of section 353 of the Public Health Service Act,[880] or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861(p)(4), or whether an ambulatory surgical center meets the standards specified under section 1832(a)(2)(F)(i), or whether screening mammography meets the standards established under section 1834(c)(3)[881]. To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, comprehensive outpatient rehabilitation facility, home health agency, or hospice program[882] (as those terms are defined in section 1861) may be treated as such by the Secretary. Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility, after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1819(a). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place, and require (in the case of skilled nursing facilities) the posting in a place readily accessible to patients (and patients' representatives),[883] the pertinent findings of each such survey relating to the compliance of each such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization. Any agreement under this subsection shall provide for the appropriate State or local agency to maintain a toll-free hotline (1) to collect, maintain, and continually update information on home health agencies located in the State or locality that are certified to participate in the program established under this title (which information shall include any significant deficiencies found with respect to patient care in the most recent certification survey conducted by a State agency or accreditation survey conducted by a private accreditation agency under section 1865 with respect to the home health agency, when that survey was completed, whether corrective actions have been taken or are planned, and the sanctions, if any, imposed under this title with respect to the agency) and (2) to receive complaints (and answer questions) with respect to home health agencies in the State or locality. Any such agreement shall provide for such State or local agency to maintain a unit for investigating such complaints that possesses enforcement authority and has access to survey and certification reports, information gathered by any private accreditation agency utilized by the Secretary under section 1865, and consumer medical records (but only with the consent of the consumer or his or her legal representative).[884]

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[876] See Vol. II, P.L. 101-508, §4008(h)(1)(A), with respect to nurse aide training and competency evaluations.

[877] P.L. 100-360, §203(e)(3)(A), inserted "or a home intravenous drug therapy provider,", applicable to items and services furnished on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "or a home intravenous drug therapy provider,", effective January 1, 1990.

[878] P.L. 101-239, §6003(g)(3)(C)(iii), inserted ", a rural primary care hospital, as defined in section 1861(mm)(1),", effective December 19, 1989.

[879] P.L. 99-509, §9320(h)(3), struck out "(11) and (12)" and substituted "(12) and (13)". For the effective date, see Vol. II, P.L. 99-509, §9320(i), as amended by P.L. 100-485.

P.L. 100-203, §4072(d), struck out "(12) and (13)" and substituted "(13) and (14)". For the effective date, see Vol. II, P.L. 100-203, §4072(e).

P.L. 100-360, §204(d)(3), struck out "(13) and (14)" and substituted "(14) and (15)", applicable to screening mammography performed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "(14) and (15)" and substituted "(13) and (14)", effective January 1, 1990.

P.L. 101-239, §6115(c), struck out "(14) and (15)" and substituted "(15) and (16)", applicable to screening pap smears performed on or after July 1, 1990. Executed as if "(14) and (15)" read "(13) and (14)".

[880] P.L. 101-508, §4154(d)(1), struck out a comma and inserted "or (in the case of a laboratory that does not participate or seek to participate in the medicare program) the requirements of section 353 of the Public Health Service Act,", effective as if included in the enactment of the Clinical Laboratory Improvement Amendments of 1988.

[881] P.L. 100-360, §204(c)(2), inserted ", or whether screening mammography meets the standards established under section 1834(e)(3)", applicable to screening mammography performed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out ", or whether screening mammography meets the standards established under section 1834(e)(3)", effective January 1, 1990.

P.L. 101-508, §4163(c)(2), inserted ", or whether screening mammography meets the standards established under section 1834(c)(3)", applicable to screening mammography performed on or after January 1, 1991.

(b) The Secretary shall pay any such State, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (a), and for the Federal Hospital Insurance Trust Fund's fair share of the costs attributable to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under part A, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

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[882] P.L. 100-360, §203(e)(3)(B), struck out "or hospice program" and substituted "hospice program, or home intravenous drug therapy provider", applicable to items and services furnished on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "hospice program, or home intravenous drug therapy provider" and substituted "or hospice program", effective January 1, 1990.

[883] P.L. 100-203, §4202(c), inserted ", and require (in the case of skilled nursing facilities) the posting in a place readily accessible to patients (and patients' representatives),". For the effective date, see Vol. II, P.L. 100-203, §4204(a).

[884] See Vol. II, P.L. 101-239, §6901(d)(3), with respect to medicare waiver authority for certain demonstration projects in New York and Wisconsin.

(c) The Secretary is authorized to enter into an agreement with any State under which the appropriate State or local agency which performs the certification function described in subsection (a) will survey, on a selective sample basis (or where the Secretary finds that a survey is appropriate because of substantial allegations of the existence of a significant deficiency or deficiencies which would, if found to be present, adversely affect health and safety of patients), hospitals which have an agreement with the Secretary under section 1866 and which are accredited by the Joint Commission on Accreditation of Hospitals. The Secretary shall pay for such services in the manner prescribed in subsection (b).

(d) The Secretary may not enter an agreement under this section with a State with respect to determining whether an institution therein is a skilled nursing facility unless the State meets the requirements specified in section 1819(e) and section 1819(g)[885] and the establishment of remedies under sections 1819(h)(2)(B) and 1819(h)(2)(C) (relating to establishment and application of remedies)[886]. [887]

(e) Notwithstanding any other provision of law, the Secretary may not impose, or require a State to impose, any fee on any facility or entity subject to a determination under subsection (a), or any renal dialysis facility subject to the requirements of section 1881(b)(1), for any such determination or any survey relating to determining the compliance of such facility or entity with any requirement of this title.[888]

EFFECT OF ACCREDITATION

SEC. 1865. [42 U.S.C. 1395bb] (a) Except as provided in subsection (b) and the second sentence of section 1863, if—

(1) an institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals, and

(2)(A)[889] such institution[890] authorizes the Commission to release to the Secretary upon his request (or such State agency as the Secretary may designate) a copy of the most current accreditation survey of such institution made by such Commission, together with any other information directly related to the survey as the Secretary may require (including corrective action plans),[891]

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[885] P.L. 100-203, §4202(a)(1), inserted "and section 1819(g)". For the effective date, see Vol. II, P.L. 100-203, §4204(a).

[886] P.L. 100-203, §4203(a)(1), inserted "and the establishment of remedies under sections 1819(h)(2)(B) and 1819(h)(2)(C) (relating to establishment and application of remedies)". For the effective date, see Vol. II, P.L. 100-203, §4204(b) (as added by P.L. 100-360, §411(l)(9)(B)(iii)).

[887] P.L. 100-203, §4201(a)(2), added subsection (d). For the effective date, see Vol. II, P.L. 100-203, §4204(a).

[888] P.L. 101-508, §4027(sic)(g), added subsection (e), effective November 5, 1990.

[889] P.L. 101-239, §6019(a)(1), inserted "(A)", effective June 19, 1990.

[890] P.L. 101-239, §6019(a)(2), struck out "(if it is included within a survey described in section 1864(c))", effective June 19, 1990.

(B) such Commission releases such a copy and any such information to the Secretary,[892]

then, such institution shall be deemed to meet the requirements of the numbered paragraphs of section 1861(e); except—

(3) paragraph (6) thereof, and

(4) any standard, promulgated by the Secretary pursuant to paragraph (9) thereof, which is higher than the requirements prescribed for accreditation by such Commission.

If such Commission, as a condition for accreditation of a hospital, requires a utilization review plan (or imposes another requirement which serves substantially the same purpose), requires a discharge planning process (or imposes another requirement which serves substantially the same purpose), or imposes a standard which the Secretary determines is at least equivalent to the standard promulgated by the Secretary as described in paragraph (4) of this subsection, the Secretary is authorized to find that all institutions so accredited by such Commission comply also with clause (A) or (B) of section 1861(e)(6) or the standard described in such paragraph (4), as the case may be. In addition, if the Secretary finds that accreditation of an entity by the American Osteopathic Association or any other national accreditation body provides reasonable assurance that any or all of the conditions of section 1832(a)(2)(F)(i), 1834(c)(3),[893] 1861(e), 1861(f), 1861(j), 1861(o), 1861(p)(4)(A) or (B), paragraphs (15) and (16)[894] of section 1861(s), section 1861(aa)(2), 1861(cc)(2), 1861(dd)(2), or 1861(mm)(1)[895], as the case may be, are met, he may, to the extent he deems it appropriate, treat such entity as meeting the condition or conditions with respect to which he made such finding. The Secretary may not disclose any accreditation survey (other than a survey with respect to a home health agency) made and released to him by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association, or any other national accreditation body, of an entity accredited by such body, except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary.[896]

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[891] P.L. 101-239, §6019(a)(3), inserted "together with any other information directly related to the survey as the Secretary may require (including corrective action plans),", effective June 19, 1990.

[892] P.L. 101-239, §6019(a)(4), added subparagraph (B), effective June 19, 1990.

[893] P.L. 100-360, §204(c)(3), inserted "1834(e)(3),", applicable to screening mammography performed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "1834(e)(3),", effective January 1, 1990.

P.L. 101-508, §4163(c)(3), inserted "1834(c)(3),", applicable to screening mammography performed on or after January 1, 1991.

[894] P.L. 99-509, §9320(h)(3), struck out "(11) and (12)" and substituted "(12) and (13)". For the effective date, see Vol. II, P.L. 99-509, §9320(i), as amended by P.L. 100-485.

P.L. 100-203, §4072(d), struck out "(12) and (13)" and substituted "(13) and (14)". For the effective date, see Vol. II, P.L. 100-203, §4072(e).

P.L. 100-360, §204(d)(3), struck out "(13) and (14)" and substituted "(14) and (15)", applicable to screening mammography performed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "(14) and (15)" and substituted "(13) and (14)", effective January 1, 1990.

P.L. 101-239, §6115(c), struck out "(14) and (15)" and substituted "(15) and (16)", applicable to screening pap smears performed on or after July 1, 1990. Executed as if "(14) and (15)" read "(13) and (14)".

[895] P.L. 101-239, §6003(g)(3)(C)(iv), struck out "or 1861(dd)(2)" and substituted "1861(dd)(2), or 1861(mm)(1)", effective December 19, 1989.

(b) Notwithstanding any other provision of this title, if the Secretary finds[897] that a hospital has significant deficiencies (as defined in regulations pertaining to health and safety), the hospital shall, after the date of notice of such finding to the hospital and for such period as may be prescribed in regulations, be deemed not to meet the requirements of the numbered paragraphs of section 1861(e).

AGREEMENTS WITH PROVIDERS OF SERVICES[898]

SEC. 1866. [42 U.S.C. 1395cc] (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)),

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9) of section 1862(a), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title,

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person,

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this title) with respect to the provider,

(E) to release data with respect to patients of such provider upon request to an organization having a contract with the Secretary under part B of title XI as may be necessary (i) to allow such organization to carry out its functions under such contract, or (ii) to allow such organization to carry out similar review functions under any contract the organization may have with a private or public agency paying for health care in the same area with respect to patients who authorize release of such data for such purposes,

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[896] P.L. 101-239, §6019(b), struck out the period and substituted ", except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary.", effective December 19, 1989.

[897] P.L. 101-239, §6019(c), struck out "following a survey made pursuant to section 1864(c)", effective December 19, 1989.

[898] See Vol. II, P.L. 97-248, §119, with respect to private sector review initiative and restriction against recovery from beneficiaries.

(F)(i) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b), (c), or (d) of section 1886, to maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a utilization and quality control peer review organization which has a contract with the Secretary under part B of title XI for the area in which the hospital is located, under which the organization will perform functions under that part with respect to the review of the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1886(d)(5), with respect to inpatient hospital services for which payment may be made under part A of this title (and for purposes of payment under this title, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A, and (I) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, (II) shall be transferred from the Federal Hospital Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and (III) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1988 for direct and administrative costs (adjusted for inflation and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year)[899] of such reviews)[900],

(ii) in the case of hospitals, rural primary care hospitals,[901] skilled nursing facilities, and home health agencies, to maintain an agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the hospital, facility, or agency is located) to perform the functions described in paragraph (3)(A),[902]

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1886, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A but for a denial or reduction of payments under section 1886(f)(2),

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[899] P.L. 101-234, §301(b)(4), struck out a closing parenthesis, effective December 19, 1989.

P.L. 101-234, §301(d)(1), made the same amendment.

[900] P.L. 101-508, §4008(m)(3)(G)(sic)(i), inserted a closing parenthesis, effective November 5, 1990.

[901] P.L. 101-239, §6003(g)(3)(D)(xii)(I), inserted "rural primary care hospitals,", effective December 19, 1989.

[902] P.L. 101-508, §4008(m)(3)(G)(sic)(ii), struck out "(4)(A);" and substituted "(3)(A),", effective November 5, 1990.

(H) in the case of hospitals which provide services for which payment may be made under this title and in the case of rural primary care hospitals which provide rural primary care hospital services[903], to have all items and services (other than physicians' services as defined in regulations for purposes of section 1862(a)(14), and other than services described by section 1861(s)(2)(K)(i), certified nurse-midwife services, qualified psychologist services, and[904] services of a certified registered nurse anesthetist[905]) (i) that are furnished to an individual who is a patient of the hospital, and (ii) for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital,[906]

(I) in the case of a hospital or rural primary care hospital—

(i) to adopt and enforce a policy to ensure compliance with the requirements of section 1867 and to meet the requirements of such section[907],

(ii) to maintain medical and other records related to individuals transferred to or from the hospital for a period of five years from the date of the transfer, and

(iii) to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition;[908]

(J) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of title 10, or under section 613 of title 38, United States Code, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of title 10, United States Code,[909]

(K) not to charge any individual or any other person for items or services for which payment under this title is denied under section 1154(a)(2) by reason of a determination under section 1154(a)(1)(B),

(L) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under section 603 of title 38, United States Code, in accordance with such admission practices, and such payment methodology and amounts, as are prescribed under joint regulations issued by the Secretary and by the Administrator of Veterans' Affairs in implementation of such section,[910]

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[903] P.L. 101-239, §6003(g)(3)(D)(xii)(II), inserted "and in the case of rural primary care hospitals which provide rural primary care hospital services", effective December 19, 1989.

[904] P.L. 101-508, §4157(c)(2), inserted "services described by section 1861(s)(2)(K)(i), certified nurse-midwife services, qualified psychologist services, and", applicable to services furnished on or after January 1, 1991.

[905] P.L. 99-509, §9320(h)(2), inserted ", and other than services of a certified registered nurse anesthetist". For the effective date, see Vol. II, P.L. 99-509, §9320(i), as amended by P.L. 100-485.

[906] See Vol. II, P.L. 98-21, §602(k), with respect to certain conditions under which the Secretary may waive the requirements of this provision.

[907] P.L. 101-508, §4008(b)(3)(B), inserted "and to meet the requirements of such section", applicable to actions occurring on or after May 1, 1991.

[908] P.L. 101-239, §6018(a)(1), amended subparagraph (I) in its entirety, effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by that date. [For subparagraph (I) as it formerly read, see Vol. III, P.L. 101-239.]

[909] See Vol. II, P.L. 99-272, §9122(c) and (d), with respect to the study and report to Congress on the requirement for Medicare hospitals to participate in the CHAMPUS and CHAMPVA programs.

(M) in the case of hospitals, to provide to each individual who is entitled to benefits under part A (or to a person acting on the individual's behalf), at or about the time of the individual's admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains—

(i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this title,

(ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,

(iii) the individual's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and

(iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal,

and which provides such additional information as the Secretary may specify,

(N) in the case of hospitals and rural primary care hospitals[911]—

(i) to make available to its patients the directory or directories of participating physicians (published under section 1842(h)(4)) for the area served by the hospital or rural primary care hospital[912], [913]

(ii) if hospital personnel (including staff of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis, the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one qualified participating physician who is listed in such a directory and from whom the patient may receive the necessary services,[914]

(iii) to post conspicuously in any emergency department a sign (in a form specified by the Secretary) specifying rights of individuals under section 1867 with respect to examination and treatment for emergency medical conditions and women in labor, and[915]

(iv) to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital participates in the medicaid program under a State plan approved under title XIX, and[916]

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[910] See Vol. II, P.L. 99-576, §233(c), with respect to the report to Congress.

[911] P.L. 101-239, §6003(g)(3)(D)(xii)(IV), inserted "and rural primary care hospitals", effective December 19, 1989.

[912] P.L. 101-239, §6003(g)(3)(D)(xii)(IV), inserted "or rural primary care hospital", effective December 19, 1989.

[913] P.L. 101-239, §6018(a)(2)(A), struck out "and".

[914] P.L. 101-239, §6112(e)(3)(A), struck out "and".

P.L. 101-239, §6018(a)(2)(B), made the same amendment.

[915] P.L. 101-239, §6018(a)(2)(C), added this clause, effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by that date.

[916] P.L. 101-239, §6018(a)(2)(C), added this clause, effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by that date.

(O) in the case of hospitals and skilled nursing facilities, to accept as payment in full for inpatient hospital and extended care services that are covered under this title and are furnished to any individual enrolled with an eligible organization (i) with a risk-sharing contract under section 1876, under section 1876(i)(2)(A) (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967[917], or under section 222(a) of the Social Security Amendments of 1972[918], and (ii) which does not have a contract establishing payment amounts for services furnished to members of the organization the amounts (in the case of hospitals) or limits (in the case of skilled nursing facilities) that would be made as a payment in full under this title if the individuals were not so enrolled;[919]

(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this title who require catheters, catheter supplies, ostomy bags, and supplies related to ostomy care[920] (described in section 1861(m)(5)), to offer to furnish such supplies to such an individual as part of their furnishing of home health services, and[921]

(Q) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to comply with the requirement of subsection (f) (relating to maintaining written policies and procedures respecting advance directives).[922]

In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of title XI is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1), (a)(3), or (a)(4), section 1833(b),[923] or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary[924]). In the case of items and services described in section 1833(c)[925], clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10)(A), with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), and with respect to clinical diagnostic laboratory tests for which payment is made under part B. Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1834(a), the amount of any deduction imposed under section 1833(b) and 20 percent of the payment basis described in section 1834(a)(1)(B).[926]

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[917] P.L. 90-248.

[918] P.L. 92-603.

[919] P.L. 101-239, §6112(e)(3)(B), struck out the period and substituted "; and".

P.L. 101-508, §4206(a)(1)(A), struck out "and".

[920] P.L. 101-508, §4153(d)(1), struck out "ostomy supplies" and inserted "catheters, catheter supplies, ostomy bags, and supplies related to ostomy care", effective as if included in the enactment of P.L. 101-239.

[921] P.L. 101-239, §6112(e)(3)(C), added subparagraph (P), applicable with respect to items furnished on or after January 1, 1990.

P.L. 101-508, §4206(a)(1)(B), struck out a period and substituted ", and".

[922] P.L. 101-508, §4206(a)(1)(C), added subparagraph (Q), applicable to services furnished on or after December 1, 1991.

See Vol. II, P.L. 101-508, §4206(c), with respect to the effect on State law.

[923] P.L. 100-360, §202(b)(1)(A), inserted "1834(c),", applicable to items dispensed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "1834(c),", effective January 1, 1990.

(B)[927] Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider of services may also charge such individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this title.

[(ii) Repealed.[928]**]**

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1813(a)(2), except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this title, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined), and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf. For purposes of subparagraph (C), whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is imposed under section 1813(a)(2).

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[924] P.L. 100-360, §202(h)(1)(B), inserted "and in the case of covered outpatient drugs, applicable coinsurance percent (specified in section 1834(c)(2)(C)) of the lesser of the actual charges for the drugs or the payment limit (established under section 1834(c)(3))", applicable to items dispensed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "and in the case of covered outpatient drugs, applicable coinsurance percent (specified in section 1834(c)(2)(C)) of the lesser of the actual charges for the drugs or the payment limit (established under section 1834(c)(3))", effective January 1, 1990.

[925] P.L. 101-234, §201(a)(1), struck out "1833(d)(1)" and substituted "1833(c)", effective January 1, 1990.

[926] P.L. 101-234, §201(a)(1), struck out "A provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1833(c) (relating to catastrophic benefits).", effective January 1, 1990.

[927] P.L. 101-239, §6017(1), struck out "(i)".

[928] P.L. 101-239, §6017(2), repealed clause (ii), effective December 19, 1989. **[**For clause (ii) as it formerly read, see Vol. III, P.L. 101-239.**]**

(D) Where a provider of services customarily furnishes items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider, notwithstanding the preceding provisions of this paragraph, may not, under the authority of section 1866(a)(2)(B)(ii), charge any individual or other person any amount for such items or services in excess of the amount of the payment which may otherwise be made for such items or services under this title if the admitting physician has a direct or indirect financial interest in such provider.

(3)(A) Under the agreement required under paragraph (1)(F)(ii), the peer review organization must perform functions (other than those covered under an agreement under paragraph (1)(F)(i)) under the third sentence of section 1154(a)(4)(A) and under section 1154(a)(14) with respect to services, furnished by the hospital, rural primary care hospital,[929] facility, or agency involved, for which payment may be made under this title.

(B) For purposes of payment under this title, the cost of such an agreement to the hospital, rural primary care hospital,[930] facility, or agency shall be considered a cost incurred by such hospital, rural primary care hospital,[931] facility, or agency in providing covered services under this title and shall be paid directly by the Secretary to the peer review organization on behalf of such hospital, rural primary care hospital,[932] facility, or agency in accordance with a schedule established by the Secretary.

(C) Such payments—

(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(ii) shall not be less in the aggregate for a fiscal year—

(I) in the case of hospitals, than the amount specified in paragraph (1)(F)(i)(III), and

(II) in the case of facilities, rural primary care hospitals,[933] and agencies, than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such facilities, rural primary care hospitals,[934] or agencies under part B of title XI.

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[929] P.L. 101-239, §6003(g)(3)(D)(xiii)(I), inserted "rural primary care hospital,", effective December 19, 1989.

[930] P.L. 101-239, §6003(g)(3)(D)(xiii)(I), inserted "rural primary care hospital,", effective December 19, 1989.

[931] P.L. 101-239, §6003(g)(3)(D)(xiii)(I), inserted "rural primary care hospital,", effective December 19, 1989.

[932] P.L. 101-239, §6003(g)(3)(D)(xiii)(I), inserted "rural primary care hospital,", effective December 19, 1989.

[933] P.L. 101-239, §6003(g)(3)(D)(xiii)(II), inserted ", rural primary care hospitals,", effective December 19, 1989.

[934] P.L. 101-239, §6003(g)(3)(D)(xiii)(II), inserted ", rural primary care hospitals,", effective December 19, 1989.

(b)(1) A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

(A) has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this title and regulations thereunder, or with a corrective action required under section 1886(f)(2)(B),

(B) has determined that the provider fails substantially to meet the applicable provisions of section 1861, or

(C) has excluded the provider from participation in a program under this title pursuant to section 1128 or section 1128A.

(3) A termination of an agreement or a refusal to renew an agreement under this subsection shall become effective on the same date and in the same manner as an exclusion from participation under the programs under this title becomes effective under section 1128(c).

(c)(1) Where the Secretary has terminated or has refused to renew an agreement under this title with a provider of services, such provider may not file another agreement under this title unless the Secretary finds that the reason for the termination or nonrenewal has been removed and that there is reasonable assurance that it will not recur.

(2)[935] Where the Secretary has terminated or has refused to renew an agreement under this title with a provider of services, the Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under title XIX of such termination or nonrenewal.

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1861(k) of long-stay cases in a hospital or skilled nursing facility, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or facility after a subsequent date specified by him, no payment shall be made under this title for inpatient hospital services (including inpatient psychiatric hospital services) after the 20th day of a continuous period of such services or for post-hospital[936] extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be. Such decision may be made effective only after such notice to the hospital, or (in the case of a skilled nursing facility) to the facility and the hospital or hospitals with which it has a transfer agreement, and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The

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[935] P.L. 100-203, §4212(e)(4), struck out the former paragraph (2) and redesignated the former paragraph (3) as paragraph (2). For the effective date, see Vol. II, P.L. 100-203, §4214. **[For paragraph (2) as it formerly read, see Vol. III, P.L. 100-203.]**

[936] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.

Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

(e) For purposes of this section, the term "provider of services" shall include—

(1) a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of section 1861(g)), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of section 1861(g)), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services; and

(2) a community mental health center (as defined in section 1861(ff)(3)(B)), but only with respect to the furnishing of partial hospitalization services (as described in section 1861(ff)(1)).[937]

(f)(1) For purposes of subsection (a)(1)(Q) and sections 1819(c)(2)(E), 1833(r), 1876(c)(8), and 1891(a)(6), the requirement of this subsection is that a provider of services or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) to provide written information to each such individual concerning—

(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the written policies of the provider or organization respecting the implementation of such rights;

(B) to document in the individual's medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

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[937] P.L. 101-508, §4162(b)(2), struck out "a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of section 1861(g)), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of section 1861(g)), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services." and substituted a dash and paragraphs (1) and (2), applicable to partial hospitalization services provided on or after October 1, 1991.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a skilled nursing facility, at the time of the individual's admission as a resident,

(C) in the case of a home health agency, in advance of the individual coming under the care of the agency,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of an eligible organization (as defined in section 1876(b)) or an organization provided payments under section 1833(a)(1)(A), at the time of enrollment of the individual with the organization.

(3) In this subsection, the term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.[938]

(g) Except as permitted under subsection (a)(2), any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment inconsistent with an arrangement under subsection (a)(1)(H) or in violation of the requirement for such an arrangement, is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(h)(1) Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(2) An institution or agency is not entitled to separate notice and opportunity for a hearing under both section 1128 and this section with respect to a determination or determinations based on the same underlying facts and issues.

(i)(1) If the Secretary determines that a psychiatric hospital which has an agreement in effect under this section no longer meets the requirements for a psychiatric hospital under this title and further finds that the hospital's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the Secretary shall terminate such agreement; or

(B) do not immediately jeopardize the health and safety of its patients, the Secretary may terminate such agreement, or provide that no payment will be made under this title with respect to any individual admitted to such hospital after the effective date of the finding, or both.

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[938] P.L. 101-508, §4206(a)(2), added subsection (f), applicable to services furnished on or after December 1, 1991.

See Vol. II, P.L. 101-508, §4206(c), with respect to the effect on State law.

(2) If a psychiatric hospital, found to have deficiencies described in paragraph (1)(B), has not complied with the requirements of this title—

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the Secretary shall provide that no payment will be made under this title with respect to any individual admitted to such hospital after the end of such 3-month period, or

(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no payment may be made under this title with respect to any individual in the hospital until the Secretary finds that the hospital is in compliance with the requirements of this title.[939]

EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN [940] LABOR[941]

Sec. 1867. [42 U.S.C. 1395dd] (a) Medical Screening Requirement.—In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department,[942] to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists[943].

(b) Necessary Stabilizing Treatment for Emergency Medical Conditions and [944] Labor.—

(1) In general.—If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition[945], the hospital must provide either—

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition[946], or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) Refusal to consent to treatment.—A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further

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[939] P.L. 101-239, §6020, added subsection (i), effective December 19, 1989.

[940] P.L. 101-239, §6211(h)(2)(A), struck out "ACTIVE", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[941] See Vol. II, P.L. 101-508, §4008(c), with respect to a study by the Inspector General.

[942] P.L. 101-239, §6211(a), inserted ", including ancillary services routinely available to the emergency department,", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[943] P.L. 101-239, §6211(h)(2)(B), struck out "or to determine if the individual is in active labor (within the meaning of subsection (e)(2))", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[944] P.L. 101-239, §6211(h)(2)(C), struck out "Active", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[945] P.L. 101-239, §6211(h)(2)(D)(i), struck out "or is in active labor", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[946] P.L. 101-239, §6211(h)(2)(D)(ii), struck out "or to provide for treatment of the labor", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment,[947] but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and[948] treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.[949]

(3) Refusal to consent to transfer.—A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer,[950] but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.[951]

(c) Restricting Transfers Until Individual[952] Stabilized.—

(1) Rule.—If an individual[953] at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B))[954], the hospital may not transfer the individual[955] unless—

(A)(i) the individual[956] (or a legally responsible person acting on the individual's[957] behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility[958], [959]

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[947] P.L. 101-239, §6211(b)(1)(A), inserted "and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment,", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[948] P.L. 101-239, §6211(b)(1)(B), struck out "or" and substituted "and", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[949] P.L. 101-239, §6211(b)(1)(C), added this sentence, effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[950] P.L. 101-239, §6211(b)(2)(A), inserted "and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer,", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[951] P.L. 101-239, §6211(b)(2)(B), added this sentence, effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[952] P.L. 101-239, §6211(g)(1)(A), struck out "Patient" and substituted "Individual", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[953] P.L. 101-239, §6211(g)(1)(B), struck out "a patient" and substituted "an individual", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[954] P.L. 101-239, §6211(h)(2)(E), struck out "(e)(4)(B)) or is in active labor" and substituted "(e)(3)(B))", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[955] P.L. 101-239, §6211(g)(1)(B), struck out "patient" and substituted "individual", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[956] P.L. 101-239, §6211(g)(1)(B), struck out "patient" and substituted "individual", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[957] P.L. 101-239, §6211(g)(1)(B), struck out "patient's" and substituted "individual's", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[958] P.L. 101-239, §6211(c)(1), struck out "requests that the transfer be effected" and substituted "after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[959] P.L. 101-239, §6211(c)(2)(A), struck out "or".

(ii) a physician (within the meaning of section 1861(r)(1))[960] has signed a certification that[961] based upon the information available at the time of transfer[962], the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child[963] from effecting the transfer, or[964]

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1861(r)(1)), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and[965]

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.[966]

(2) Appropriate transfer.—An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;[967]

(B)[968] in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the individual[969], and

(ii) has agreed to accept transfer of the individual[970] and to provide appropriate medical treatment;

(C)[971] in which the transferring hospital sends to[972] the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C)[973]) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment[974];

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[960] P.L. 101-239, §6211(c)(2)(B)(i), struck out ", or other qualified medical personnel when a physician is not readily available in the emergency department,", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[961] P.L. 101-239, §6211(c)(3)(A), struck out ", based upon the reasonable risks and benefits to the patient, and", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[962] P.L. 101-239, §6211(c)(2)(B)(ii), inserted "of transfer", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[963] P.L. 101-239, §6211(c)(3)(B), struck out "individual's medical condition" and substituted "individual and, in the case of labor, to the unborn child", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[964] P.L. 101-239, §6211(c)(2)(C), struck out "; and" and substituted ", or".

[965] P.L. 101-239, §6211(c)(2)(D), added clause (iii), effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[966] P.L. 101-239, §6211(c)(4), added this sentence, effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[967] P.L. 101-239, §6211(c)(5)(B), added this subparagraph (A), effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[968] P.L. 101-239, §6211(c)(5)(A), redesignated subparagraph (A) as subparagraph (B).

[969] P.L. 101-239, §6211(g)(1)(B), struck out "patient" and substituted "individual", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[970] P.L. 101-239, §6211(g)(1)(B), struck out "patient" and substituted "individual", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[971] P.L. 101-239, §6211(c)(5)(A), redesignated subparagraph (B) as subparagraph (C).

[972] P.L. 101-239, §6211(d)(1), struck out "provides" and substituted "sends to", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

(D)[975] in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E)[976] which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals[977] transferred.

(d) ENFORCEMENT.—

(1)[978] CIVIL MONETARY PENALTIES.—(A) A participating hospital that negligently[979] violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds)[980] for each such violation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a).

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently[981] violates a requirement of this section, including a physician who—

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[973] P.L. 101-508, §4008(b)(3)(A)(iii), struck out "(d)(2)(C)" and substituted "(d)(1)(C)", applicable to actions occurring on or after May 1, 1991.

[974] P.L. 101-239, §6211(d)(2), struck out "with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital" and substituted "all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(2)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[975] P.L. 101-239, §6211(c)(5)(A), redesignated subparagraph (C) as subparagraph (D).

[976] P.L. 101-239, §6211(c)(5)(A), redesignated subparagraph (D) as subparagraph (E).

[977] P.L. 101-239, §6211(g)(1)(B), struck out "patients" and substituted "individuals", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[978] P.L. 101-508, §4008(b)(3)(A)(i), struck out paragraph (1), applicable to actions occurring on or after May 1, 1991. [For paragraph (1) as it formerly read, see Vol. III, P.L. 101-508.]

P.L. 101-508, §4008(b)(3)(A)(ii), redesignated paragraph (2) as paragraph (1), applicable to actions occurring on or after May 1, 1991.

[979] P.L. 101-508, §4008(b)(1), struck out "knowingly" and substituted "negligently", applicable to actions occurring on or after May 1, 1991.

[980] P.L. 101-508, §4008(b)(2), inserted "(or not more than $25,000 in the case of a hospital with less than 100 beds)", applicable to actions occurring on or after May 1, 1991.

[981] P.L. 101-508, §4027(sic)(a)(2), struck out "knowingly" and substituted "negligently", applicable to actions occurring on or after May 1, 1991.

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is[982] is gross and flagrant or is repeated[983], to exclusion from participation in this title and State health care programs. The provisions of section 1128A (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1128A(a).[984]

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1866(a)(1)(I)) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.[985]

(2)[986] CIVIL ENFORCEMENT.—

(A) PERSONAL HARM.—Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) FINANCIAL LOSS TO OTHER MEDICAL FACILITY.—Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

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[982] As in original; one "is" should be stricken.

[983] P.L. 101-508, §4027(sic)(a)(3), struck out "knowing and willful or negligent" and substituted "is gross and flagrant or is repeated", applicable to actions occurring on or after May 1, 1991.

[984] P.L. 101-239, §6211(e)(1), amended subparagraph (B) in its entirety, effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date. [For subparagraph (B) as it formerly read, see Vol. III, P.L. 101-239.]

[985] P.L. 101-239, §6211(e)(2), amended subparagraph (C) in its entirety, effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by *such date. [For subparagraph (C) as it formerly read, see Vol. III, P.L. 101-239.]*

[986] P.L. 101-508, §4008(b)(3)(A)(ii), redesignated paragraph (3) as paragraph (2), applicable to actions occurring on or after May 1, 1991.

(C) LIMITATIONS ON ACTIONS.—No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) CONSULTATION WITH PEER REVIEW ORGANIZATIONS.—In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1), the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of title XI) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review.[987]

(e) DEFINITIONS.—In this section:

(1) The term "emergency medical condition" means—

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant women[988] who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.[989]

(2)[990] The term "participating hospital" means[991] hospital that has entered into a provider agreement under section 1866.

(3)[992](A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A)[993], to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during[994] the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta)[995].

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[987] P.L. 101-508, §4027(sic)(a)(1)(A), added paragraph (3), effective February 1, 1991.

[988] As in original; possibly should read "woman".

[989] P.L. 101-239, §6211(h)(1)(A), struck out "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in"; amended subparagraphs (A) and (B) in their entirety; and struck out subparagraph (C), effective July 1, 1990, without regard to whether regulations to carry out these amendments have been promulgated by such date. [For subparagraphs (A), (B), and (C) as they formerly read, see Vol. III, P.L. 101-239.]

[990] P.L. 101-239, §6211(h)(1)(B), struck out paragraph (2), and §6211(h)(1)(E), redesignated paragraph (3) as paragraph (2), effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date. [For paragraph (2) as it formerly read, see Vol. III, P.L. 101-239.]

[991] As in original; possibly should insert "a".

[992] P.L. 101-239, §6211(h)(1)(E), redesignated paragraph (4) as paragraph (3).

[993] P.L. 101-239, §6211(h)(1)(C)(i), inserted "described in paragraph (1)(A)", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[994] P.L. 101-239, §6211(h)(1)(C)(ii), inserted "or occur during", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A)[996], that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during[997] the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta)[998].

(4)[999] The term "transfer" means the movement (including the discharge) of an individual[1000] outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual[1001] who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5)[1002] The term "hospital" includes a rural primary care hospital (as defined in section 1861(mm)(1)).[1003]

(f) Preemption.—The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination.—A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.[1004]

(h) No Delay in Examination or Treatment.—A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.[1005]

(i) Whistleblower Protections.—A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.[1006]

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[995] P.L. 101-239, §6211(h)(1)(C)(iii), inserted ", or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta)", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[996] P.L. 101-239, §6211(h)(1)(D)(i), inserted "described in paragraph (1)(A)", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[997] P.L. 101-239, §6211(h)(1)(D)(ii), inserted "or occur during", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[998] P.L. 101-239, §6211(h)(1)(D)(iii), inserted ", or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta)", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[999] P.L. 101-239, §6211(h)(1)(E), redesignated paragraph (5) as paragraph (4).

[1000] P.L. 101-239, §6211(g)(2), struck out "a patient" and substituted "an individual", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[1001] P.L. 101-239, §6211(g)(2), struck out "a patient" and substituted "an individual", effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[1002] P.L. 101-239, §6211(h)(1)(E), redesignated paragraph (6) as paragraph (5).

[1003] P.L. 101-239, §6003(g)(3)(D)(xiv), added this paragraph, effective December 19, 1989.

[1004] P.L. 101-239, §6211(f), added subsection (g), effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[1005] P.L. 101-239, §6211(f), added subsection (h), effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

PRACTICING PHYSICIANS ADVISORY COUNCIL[1007]

SEC. 1868. [42 U.S.C. 1395ee] (a) The Secretary shall appoint, based upon nominations submitted by medical organizations representing physicians, a Practicing Physicians Advisory Council (in this section referred to as the "Council") to be composed of 15 physicians, each of whom has submitted at least 250 claims for physicians' services under this title in the previous year. At least 11 of the members of the Council shall be physicians described in section 1861(r)(1) and the members of the Council shall include both participating and nonparticipating physicians and physicians practicing in rural areas and underserved urban areas.

(b) The Council shall meet once during each calendar quarter to discuss certain proposed changes in regulations and carrier manual instructions related to physician services identified by the Secretary. To the extent feasible and consistent with statutory deadlines, such consultation shall occur before the publication of such proposed changes.

(c) Members of the Council shall be entitled to receive reimbursement of expenses and per diem in lieu of subsistence in the same manner as other members of advisory councils appointed by the Secretary are provided such reimbursement and per diem under this title.

DETERMINATIONS; APPEALS

SEC. 1869. [42 U.S.C. 1395ff] (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A or part B, and any other determination with respect to a claim for benefits under part A or a claim for benefits with respect to home health services under part B shall be made by the Secretary in accordance with regulations prescribed by him.

(b)(1) Any individual dissatisfied with any determination under subsection (a) as to—

(A) whether he meets the conditions of section 226 of this Act or section 103 of the Social Security Amendments of 1965[1008], or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this title or section 1818,

(C) the amount of benefits under part A or part B (including a determination where such amount is determined to be zero), or

(D) any other denial (other than under part B of title XI) of a claim for benefits under part A or a claim for benefits with respect to home health services under part B, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this subsection by a person that furnishes or supplies the individual, directly or indirectly, with services or items solely on the basis that the person furnishes or supplies the individual with such a service or item. Any person that furnishes services or items to an individual may not represent an individual under this subsection with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal. If a person furnishes services or items to an individual and represents the individual under this subsection, the person may not impose any financial liability on such individual in connection with such representation.[1009]

[1006] P.L. 101-239, §6211(f), added subsection (i), effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

P.L. 101-508, §4027(sic)(k)(3), amended subsection (i) in its entirety, effective November 5, 1990. [For subsection (i) as it formerly read, see Vol. III, P.L. 101-508.]

[1007] P.L. 101-508, §4112, added section 1868, effective November 5, 1990.

[1008] P.L. 89-97.

(2) Notwithstanding paragraph (1)(C) and (1)(D), in the case of a claim arising—

(A) under part A, a hearing shall not be available to an individual under paragraph (1)(C) and (1)(D) if the amount in controversy is less than $100 and judicial review shall not be available to the individual under that paragraph if the amount in controversy is less than $1,000; or

(B) under part B, a hearing shall not be available to an individual under paragraph (1)(C) and (1)(D) if the amount in controversy is less than $500 and judicial review shall not be available to the individual under that paragraph if the aggregate amount in controversy is less than $1,000.

In determining the amount in controversy, the Secretary, under regulations, shall allow two or more claims to be aggregated if the claims involve the delivery of similar or related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals.[1010]

(3) Review of any national coverage determination under section 1862(a)(1) respecting whether or not a particular type or class of items or services is covered under this title shall be subject to the following limitations:

(A) Such a determination shall not be reviewed by any administrative law judge.

(B) Such a determination shall not be held unlawful or set aside on the ground that a requirement of section 553 of title 5, United States Code, or section 1871(b), relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

(C) In any case in which a court determines that the record is incomplete or otherwise lacks adequate information to support the validity of the determination, it shall remand the matter to the Secretary for additional proceedings to supplement the record and the court may not determine that an item or service is covered except upon review of the supplemented record.

[1009] See Vol. II, P.L. 100-203, §4037, with respect to Medicare hearings and appeals.

[1010] See Vol. II, P.L. 101-508, §4113, with respect to a study of the aggregation rule for claims for similar physicians' services.

(4) A regulation or instruction which relates to a method for determining the amount of payment under part B and which was initially issued before January 1, 1981, shall not be subject to judicial review.

(5) In an administrative hearing pursuant to paragraph (1), where the moving party alleges that there are no material issues of fact in dispute, the administrative law judge shall make an expedited determination as to whether any such facts are in dispute and, if not, shall determine the case expeditiously.

OVERPAYMENT ON BEHALF OF INDIVIDUALS AND SETTLEMENT OF CLAIMS FOR BENEFITS ON BEHALF OF DECEASED INDIVIDUALS

SEC. 1870. [42 U.S.C. 1395gg] (a) Any payment under this title to any provider of services or other person with respect to any items or services furnished any individual shall be regarded as a payment to such individual.

(b) Where—

(1) more than the correct amount is paid under this title to a provider of services or other person for items or services furnished an individual and the Secretary determines (A) that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or (B) that such provider of services or other person was without fault with respect to the payment of such excess over the correct amount, or

(2) any payment has been made under section 1814(e) to a provider of services or other person for items or services furnished an individual,

proper adjustments shall be made, under regulations prescribed (after consultation with the Railroad Retirement Board) by the Secretary, by decreasing subsequent payments—

(3) to which such individual is entitled under title II of this Act or under the Railroad Retirement Act of 1974[1011], as the case may be, or

(4) if such individual dies before such adjustment has been completed, to which any other individual is entitled under title II of this Act or under the Railroad Retirement Act of 1974, as the case may be, with respect to the wages and self-employment income or the compensation constituting the basis of the benefits of such deceased individual under title II of such Act.

As soon as practicable after any adjustment under paragraph (3) or (4) is determined to be necessary, the Secretary, for purposes of this section, section 1817(g), and section 1841(f), shall certify (to the Railroad Retirement Board if the adjustment is to be made by decreasing subsequent payments under the Railroad Retirement Act of 1974) the amount of the overpayment as to which the adjustment is to be made. For purposes of clause (B) of paragraph (1), such provider of services or such other person shall, in the absence of evidence to the contrary, be deemed to be without fault if the Secretary's determination that more than such correct amount was paid was made subsequent to the third year following the year in which notice was sent to such individual that such amount had been paid; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title.

[1011] P.L. 75-162 [as amended by P.L. 93-445].

(c) There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1814(e)) with respect to an individual who is without fault or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), if such adjustment (or recovery) would defeat the purposes of title II or title XVIII or would be against equity and good conscience. Adjustment or recovery of an incorrect payment (or only such part of an incorrect payment as the Secretary determines to be inconsistent with the purposes of this title) against an individual who is without fault shall be deemed to be against equity and good conscience if (A) the incorrect payment was made for expenses incurred for items or services for which payment may not be made under this title by reason of the provisions of paragraph (1) or (9) of section 1862(a) and (B) if the Secretary's determination that such payment was incorrect was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title.[1012]

(d) No certifying or disbursing officer shall be held liable for any amount certified or paid by him to any provider of services or other person where the adjustment or recovery of such amount is waived under subsection (c) or where adjustment under subsection (b) is not completed prior to the death of all persons against whose benefits such adjustment is authorized.

(e) If an individual, who received services for which payment may be made to such individual under this title, dies, and payment for such services was made (other than under this title), and the individual died before any payment due him under this title with respect to such services was completed, payment of the amount due (including the amount of any unnegotiated checks) shall be made—

(1) if the payment for such services was made (before or after such individual's death) by a person other than the deceased individual, to the person or persons determined by the Secretary under regulations to have paid for such services, or if the payment for such services was made by the deceased individual before his death, to the legal representative of the estate of such deceased individual, if any;

(2) if there is no person who meets the requirements of paragraph (1), to the person, if any, who is determined by the Secretary to be the surviving spouse of the deceased individual and who was either living in the same household with the deceased at the time of his death or was, for the month in which the deceased individual died, entitled to a monthly benefit on the basis of the same wages and self-employment income as was the deceased individual;

[1012] See Vol. II, P.L. 101-239, §6109, with respect to waiver of liability limiting recoupment in certain cases.

(3) if there is no person who meets the requirements of paragraph (1) or (2), or if the person who meets such requirements dies before the payment due him under this title is completed, to the child or children, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(4) if there is no person who meets the requirements of paragraph (1), (2), or (3), or if each person who meets such requirements dies before the payment due him under this title is completed, to the parent or parents, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent);

(5) if there is no person who meets the requirements of paragraph (1), (2), (3), or (4), or if each person who meets such requirements dies before the payment due him under this title is completed, to the person, if any, determined by the Secretary to be the surviving spouse of the deceased individual;

(6) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), or (5), or if each person who meets such requirements dies before the payment due him under this title is completed, to the person or persons, if any, determined by the Secretary to be the child or children of the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(7) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), or (6), or if each person who meets such requirements dies before the payment due him under this title is completed, to the parent or parents, if any, of the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent); or

(8) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), (6), or (7), or if each person who meets such requirements dies before the payment due him under this title is completed, to the legal representatives of the estate of the deceased individual, if any.

(f) If an individual who received medical and other health services for which payment may be made under section 1832(a)(1) dies, and no assignment of the right to payment for such services was made by such individual before his death, and payment for such services has not been made—

(1) if the person or persons who furnished the services agree to the terms of assignment specified in section 1842(b)(3)(B)(ii) with respect to the services, payment for such services shall be made to such person or persons, and

(2) if the person or persons who furnished the services do not agree to the terms of assignment specified in section 1842(b)(3)(B)(ii) with respect to the services, payment for such services shall be made on the basis of an itemized bill to the

person who has agreed to assume the legal obligation to make payment for such services and files a request for payment (with such accompanying evidence of such legal obligation as may be required in regulations),

but only in such amount and subject to such conditions as would be applicable if the individual who received the services had not died.[1013]

(g) If an individual, who is enrolled under section 1818(c) of the Social Security Act or under section 1837, dies, and premiums with respect to such enrollment have been received with respect to such individual for any month after the month of his death, such premiums shall be refunded to the person or persons determined by the Secretary under regulations to have paid such premiums or if payment for such premiums was made by the deceased individual before his death, to the legal representative of the estate of such deceased individual, if any. If there is no person who meets the requirements of the preceding sentence such premiums shall be refunded to the person or persons in the priorities specified in paragraphs (2) through (7) of subsection (e).

REGULATIONS[1014]

Sec. 1871. [42 U.S.C. 1395hh] (a)(1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title. When used in this title, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

(2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this title shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

(b)(1) Except as provided in paragraph (2), before issuing in final form any regulation under subsection (a), the Secretary shall provide for notice of the proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon.

(2) Paragraph (1) shall not apply where—

(A) a statute specifically permits a regulation to be issued in interim final form or otherwise with a shorter period for public comment,

(B) a statute establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the date of the enactment of the statute in which the deadline is contained, or

(C) subsection (b) of section 553 of title 5, United States Code, does not apply pursuant to subparagraph (B) of such subsection.

(c)(1) The Secretary shall publish in the Federal Register, not less frequently than every 3 months, a list of all manual instructions, interpretative rules, statements of policy, and guidelines of general applicability which—

[1013] See Vol. II, P.L. 99-177, §256 [as amended by P.L. 100-119], with respect to special rules applicable to the Medicare program.

[1014] See Vol. II, P.L. 94-437, §702(b), with respect to regulations applicable to Indians.

See Vol. II, P.L. 97-248, §111, with respect to regulations concerning elimination of private room subsidy.

See Vol. II, P.L. 98-369, §2308(b)(1), with respect to rules applicable to the nominality test.

(A) are promulgated to carry out this title, but

(B) are not published pursuant to subsection (a)(1) and have not been previously published in a list under this subsection.

(2) Effective June 1, 1988, each fiscal intermediary and carrier administering claims for extended care, post-hospital extended care, home health care, and durable medical equipment benefits under this title shall make available to the public all interpretative materials, guidelines, and clarifications of policies which relate to payments for such benefits.

(3) The Secretary shall to the extent feasible make such changes in automated data collection and retrieval by the Secretary and fiscal intermediaries with agreements under section 1816 as are necessary to make easily accessible for the Secretary and other appropriate parties a data base which fairly and accurately reflects the provision of extended care, post-hospital extended care and home health care benefits pursuant to this title, including such categories as benefit denials, results of appeals, and other relevant factors, and selectable by such categories and by fiscal intermediary, service provider, and region.

APPLICATION OF CERTAIN PROVISIONS OF TITLE II

SEC. 1872. [42 U.S.C. 1395ii] The provisions of sections 206 and 216(j), and of subsections (a), (d), (e), (h), (i), (j), (k), and (l) of section 205, shall also apply with respect to this title to the same extent as they are applicable with respect to title II.

DESIGNATION OF ORGANIZATION OR PUBLICATION BY NAME

SEC. 1873. [42 U.S.C. 1395jj] Designation in this title, by name, of any nongovernmental organization or publication shall not be affected by change of name of such organization or publication, and shall apply to any successor organization or publication which the Secretary finds serves the purpose for which such designation is made.

ADMINISTRATION

SEC. 1874. [42 U.S.C. 1395kk] (a) Except as otherwise provided in this title and in the Railroad Retirement Act of 1974[1015], the insurance programs established by this title shall be administered by the Secretary. The Secretary may perform any of his functions under this title directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.

(b) The Secretary may contract with any person, agency, or institution to secure on a reimbursable basis such special data, actuarial information, and other information as may be necessary in the carrying out of his functions under this title.

(c) In the course of any hearing, investigation, or other proceeding that he is authorized to conduct under this title, the Secretary may administer oaths and affirmations.

[1015] P.L. 75-162 [as amended by P.L. 93-445].

STUDIES AND RECOMMENDATIONS

Sec. 1875. [42 U.S.C. 1395ll] (a) The Secretary shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to health care of the aged and the disabled, including studies and recommendations concerning (1) the adequacy of existing personnel and facilities for health care for purposes of the programs under parts A and B; (2) methods for encouraging the further development of efficient and economical forms of health care which are a constructive alternative to inpatient hospital care; and (3) the effects of the deductibles and coinsurance provisions upon beneficiaries, persons who provide health services, and the financing of the program.

(b) The Secretary shall make a continuing study of the operation and administration of the insurance programs under parts A and B (including a validation of the accreditation process of the Joint Commission on Accreditation of Hospitals, the operation and administration of health maintenance organizations authorized by section 226 of the Social Security Amendments of 1972[1016], the experiments and demonstration projects authorized by section 402 of the Social Security Amendments of 1967[1017] and the experiments and demonstration projects authorized by section 222(a) of the Social Security Amendments of 1972), and shall transmit to the Congress annually a report concerning the operation of such programs.[1018]

[(c) Repealed.[1019]]

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS[1020]

Sec. 1876. [42 U.S.C. 1395mm] (a)(1)(A) The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than September 7 before the calendar year concerned—

(i) a per capita rate of payment for each class of individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing contract and who are entitled to benefits under part A and enrolled under part B, and

(ii) a per capita rate of payment for each class of individuals who are so enrolled with such an organization and who are enrolled under part B only.

[1016] P.L. 92-603.

[1017] P.L. 90-248.

[1018] See Vol. II, P.L. 100-203, §4403(b), with respect to experiments and demonstration projects.

[1019] P.L. 101-239, §6103(b)(3)(A), repealed subsection (c), effective for fiscal years beginning after fiscal year 1990. [For subsection (c) as it reads until then, see Vol. III, P.L. 101-239.]

[1020] See Vol. II, P.L. 97-248, §114(c)(2)(E), [as added by P.L. 99-509, §9312(a)], with respect to the repeal of the "2 for 1" conversion requirement, and §114(e), with respect to a study of certain terminations of memberships in organizations and a report to Congress.

P.L. 99-272, §9211(e)(5), provides that the Secretary shall provide for such changes in the risk-sharing contracts which have been entered into under §1876 of the Act as may be necessary to conform to the requirements imposed by the amendments made by §9211 on a timely basis.

See Vol. II, P.L. 99-509, §9312(h), with respect to disenrollment.

See Vol. II, P.L. 100-203, §4012(c), with respect to data which the Secretary shall provide to eligible organizations; §4015, with respect to Medicare payment demonstration projects, and §4017, with respect to a study and reports by the Comptroller General on Medicare capitation rates.

See Vol. II, P.L. 100-360, §222, with respect to adjustment of contracts with prepaid health plans.

See Vol. II, P.L. 101-234, §203(b), with respect to adjustment of contracts with prepaid health plans.

See Vol. II, P.L. 101-508, §4204(f), with respect to a study of chiropractic services.

For purposes of this section, the term "risk-sharing contract" means a contract entered into under subsection (g) and the term "reasonable cost reimbursement contract" means a contract entered into under subsection (h).[1021]

(B) The Secretary shall define appropriate classes of members, based on age, disability status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

(C) The annual per capita rate of payment for each such class shall be equal to 95 percent of the adjusted average per capita cost (as defined in paragraph (4)) for that class.

(D) In the case of an eligible organization with a risk-sharing contract, the Secretary shall make monthly payments in advance and in accordance with the rate determined under subparagraph (C) and except as provided in subsection (g)(2), to the organization for each individual enrolled with the organization under this section.

(E)(i)[1022] The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(ii)(I) Subject to subclause (II), the Secretary may make retroactive adjustments under clause (i) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with an eligible organization (which has a risk-sharing contract under this section) under a health benefit plan operated, sponsored, or contributed to, by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the plan under this section, except that for purposes of making such retroactive adjustments under this clause, such period may not exceed 90 days.

(II) No adjustment may be made under subclause (I) with respect to any individual who does not certify that the organization provided the individual with the explanation described in subsection (c)(3)(E) at the time the individual enrolled with the organization.[1023]

(F)(i) At least 45 days before making the announcement under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall provide for notice to eligible organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

(ii) In each announcement made under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that eligible organizations can compute per capita rates of payment for classes of individuals located in each county (or equivalent area) which is in whole or in part within the service area of such an organization.[1024]

[1021] P.L. 101-239, §6206(a)(2), provides that before July 1, 1990, the Secretary shall provide for notice to eligible organizations of the methodology used in making the announcement required by this subparagraph for 1990.

[1022] P.L. 101-508, §4204(e)(1)(A), redesignated subparagraph (E) as clause (i).

[1023] P.L. 101-508, §4204(e)(1)(B), added clause (ii), applicable to individuals enrolling with an eligible organization (which has a risk-sharing contract under §1876) under a health benefit plan operated, sponsored, or contributed to, by the individual's employer or former employer (or the employer or former employer of the individual's spouse) on or after January 1, 1991.

(2) With respect to any eligible organization which has entered into a reasonable cost reimbursement contract, payments shall be made to such plan in accordance with subsection (h)(2) rather than paragraph (1).

(3) Subject to subsection (c)(7), payments under a contract to an eligible organization under paragraph (1) or (2) shall be instead of the amounts which (in the absence of the contract) would be otherwise payable, pursuant to sections 1814(b) and 1833(a), for services furnished by or through the organization to individuals enrolled with the organization under this section.

(4) For purposes of this section, the term "adjusted average per capita cost" means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for services covered under parts A and B, or part B only, and types of expenses otherwise reimbursable under parts A and B, or part B only (including administrative costs incurred by organizations described in sections 1816 and 1842), if the services were to be furnished by other than an eligible organization or, in the case of services covered only under section 1861(s)(2)(H), if the services were to be furnished by a physician or as an incident to a physician's service.

(5) The payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund[1025]. The portion of that payment to the organization for a month to be paid by each trust fund shall be determined as follows:

(A) In regard to expenditures by eligible organizations having risk-sharing contracts, the allocation shall be determined each year by the Secretary based on the relative weight that benefits from each fund contribute to the adjusted average per capita cost.

(B) In regard to expenditures by eligible organizations operating under a reasonable cost reimbursement contract, the initial allocation shall be based on the plan's most recent budget, such allocation to be adjusted, as needed, after cost settlement to reflect the distribution of actual expenditures.

The remainder of that payment shall be paid by the former trust fund.

[1024] P.L. 101-239, §6206(a)(1), added subparagraph (F), effective December 19, 1989.

[1025] P.L. 101-234, §202(a), struck out ", the Federal Supplementary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund" and substituted "and the Federal Supplementary Medical Insurance Trust Fund", effective January 1, 1990.

P.L. 101-234, §202(a), repealed §211 of P.L. 100-360, applicable to premiums for months beginning after December 31, 1989.

(6) Subject to subsections (c)(2)(B)(ii) and (c)(7)[1026], if an individual is enrolled under this section with an eligible organization having a risk-sharing contract, only the eligible organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.[1027]

(b) For purposes of this section, the term "eligible organization" means a public or private entity (which may be a health maintenance organization or a competitive medical plan), organized under the laws of any State, which—

(1) is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act[1028]), or

(2) meets the following requirements:

(A) The entity provides to enrolled members at least the following health care services:

(i) Physicians' services performed by physicians (as defined in section 1861(r)(1)).

(ii) Inpatient hospital services.

(iii) Laboratory, X-ray, emergency, and preventive services.

(iv) Out-of-area coverage.

(B) The entity is compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

(C) The entity provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

(D) The entity assumes full financial risk on a prospective basis for the provision of the health care services listed in subparagraph (A), except that such entity may—

(i) obtain insurance or make other arrangements for the cost of providing to any enrolled member health care services listed in subparagraph (A) the aggregate value of which exceeds $5,000 in any year,

(ii) obtain insurance or make other arrangements for the cost of health care service listed in subparagraph (A) provided to its enrolled members other than through the entity because medical necessity required their provision before they could be secured through the entity,

(iii) obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

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[1026] P.L. 101-508, §4204(c)(2), struck out "subsection (c)(7)" and substituted "subsections (c)(2)(B)(ii) and (c)(7)", applicable to national coverage determinations that are not incorporated in the determination of the per capita rate of payment for individuals enrolled for 1991 with an eligible organization which has entered into a risk-sharing contract under §1876.

[1027] See Vol. II, P.L. 99-177, §256 [as amended by P.L. 100-119], with respect to special rules applicable to the Medicare program.

[1028] P.L. 78-410.

(iv) make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

(E) The entity has made adequate provision against the risk of insolvency, which provision is satisfactory to the Secretary.

Paragraph (2)(A)(ii) shall not apply to an entity which had contracted with a single State agency administering a State plan approved under title XIX for the provision of services (other than inpatient hospital services) to individuals eligible for such services under such State plan on a prepaid risk basis prior to 1970.

(c)(1) The Secretary may not enter into a contract under this section with an eligible organization unless it meets the requirements of this subsection and subsection (e) with respect to members enrolled under this section.

(2)(A)[1029] The organization must provide to members enrolled under this section, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

(i)[1030] only those services covered under parts A and B of this title, for those members entitled to benefits under part A and enrolled under part B, or

(ii)[1031] only those services covered under part B, for those members enrolled only under such part,

which are available to individuals residing in the geographic area served by the organization, except that (I)[1032] the organization may provide such members with such additional health care services as the members may elect, at their option, to have covered, and (II)[1033] in the case of an organization with a risk-sharing contract, the organization may provide such members with such additional health care services as the Secretary may approve. The Secretary shall approve any such additional health care services which the organization proposes to offer to such members, unless the Secretary determines that including such additional services will substantially discourage enrollment by covered individuals with the organization.

(B) If there is a national coverage determination made in the period beginning on the date of an announcement under subsection (a)(1)(A) and ending on the date of the next announcement under such subsection that the Secretary projects will result in a signifcant[1034] change in the costs to the organization of providing the benefits that are the subject of such national coverage determination and that was not incorporated in the determination of the per capita rate of payment included in the announcement made at the beginning of such period—

(i) such determination shall not apply to risk-sharing contracts under this section until the first contract year that begins after the end of such period; and

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[1029] P.L. 101-508, §4204(c)(1)(B), redesignated paragraph (2) as subparagraph (A).

[1030] P.L. 101-508, §4204(c)(1)(A), redesignated subparagraph (A) as clause (i).

[1031] P.L. 101-508, §4204(c)(1)(A), redesignated subparagraph (B) as clause (ii).

[1032] P.L. 101-508, §4204(c)(1)(A), redesignated clause (i) as subclause (I).

[1033] P.L. 101-508, §4204(c)(1)(A), redesignated clause (ii) as subclause (II).

[1034] As in original; probably should be "significant".

(ii) if such coverage determination provides for coverage of additional benefits or under additional circumstances, subsection (a)(3) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period,

unless otherwise required by law.[1035]

(3)(A)(i) Each eligible organization must have an open enrollment period, for the enrollment of individuals under this section, of at least 30 days duration every year and including the period or periods[1036] specified under clause (ii), and must provide that at any time during which enrollments are accepted, the organization will accept up to the limits of its capacity (as determined by the Secretary) and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of subsection (f) or would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by the organization.

(ii)(I) If a risk-sharing contract under this section is not renewed or is otherwise terminated, eligible organizations with risk-sharing contracts under this section and serving a part of the same service area as under the terminated contract are required to have an open enrollment period for individuals who were enrolled under the terminated contract as of the date of notice of such termination. If a risk-sharing contract under this section is renewed in a manner that discontinues coverage for individuals residing in part of the service area, eligible organizations with risk-sharing contracts under this section and enrolling individuals residing in that part of the service area are required to have an open enrollment period for individuals residing in the part of the service area who were enrolled under the contract as of the date of notice of such discontinued coverage.

(II) The open enrollment periods required under subclause (I) shall be for 30 days and shall begin 30 days after the date that the Secretary provides notice of such requirement.

(III) Enrollment under this clause shall be effective 30 days after the end of the open enrollment period, or, if the Secretary determines that such date is not feasible, such other date as the Secretary specifies.[1037]

(B) An individual may enroll under this section with an eligible organization in such manner as may be prescribed in regulations and may terminate his enrollment with the eligible organization as of the beginning of the first calendar month following the date on which the request is made for such termination (or, in the case of financial insolvency of the organization, as may be prescribed by regulations) or, in the case of such an organization with a reasonable cost reimbursement contract, as may be prescribed by regulations. In the case of an individual's termination of enrollment, the organization shall provide the individual with a copy of the written request for termination of enrollment and a written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the organization and may not receive benefits under this title other than through the organization.

[1035] P.L. 101-508, §4204(c)(1)(C), added this subparagraph (B), applicable to national coverage determinations that are not incorporated in the determination of the per capita rate of payment for individuals enrolled for 1991 with an eligible organization which has entered into a risk-sharing contract under §1876.

[1036] P.L. 101-239, §6206(b)(1)(A), struck out "30-day period" and substituted "period or periods", effective February 17, 1990.

[1037] P.L. 101-239, §6206(b)(1)(B), amended clause (ii) in its entirety, effective February 17, 1990. [For clause (ii) as it formerly read, see Vol. III, P.L. 101-239.]

(C) The Secretary may prescribe the procedures and conditions under which an eligible organization that has entered into a contract with the Secretary under this subsection may inform individuals eligible to enroll under this section with the organization about the organization, or may enroll such individuals with the organization. No brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) individuals eligible to enroll with the organization under this section unless (i) at least 45 days before its distribution, the organization has submitted the material to the Secretary for review and (ii) the Secretary has not disapproved the distribution of the material. The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

(D) The organization must provide assurances to the Secretary that it will not expel or refuse to re-enroll any such individual because of the individual's health status or requirements for health care services, and that it will notify each such individual of such fact at the time of the individual's enrollment.[1038]

(E) Each eligible organization shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee's rights under this section, including an explanation of—

(i) the enrollee's rights to benefits from the organization,

(ii) the restrictions on payments under this title for services furnished other than by or through the organization,

(iii) out-of-area coverage provided by the organization,

(iv) the organization's coverage of emergency services and urgently needed care, and

(v) appeal rights of enrollees.

(F) Each eligible organization that provides items and services pursuant to a contract under this section shall provide assurances to the Secretary that in the event the organization ceases to provide such items and services, the organization shall provide or arrange for supplemental coverage of benefits under this title related to a preexisting condition with respect to any exclusion period, to all individuals enrolled with the entity who receive benefits under this title, for the lesser of six months or the duration of such period.

(G)(i) Each eligible organization having a risk-sharing contract under this section shall notify individuals eligible to enroll with the organization under this section and individuals enrolled with the organization under this section that—

(I) the organization is authorized by law to terminate or refuse to renew the contract, and

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[1038] See Vol. II, P.L. 98-369, §2350(a)(2), with respect to phasing in the amendments made by P.L. 98-369, §2350(a)(1).

(II) termination or nonrenewal of the contract may result in termination of the enrollments of individuals enrolled with the organization under this section.

(ii) The notice required by clause (i) shall be included in—

(I) any marketing materials described in subparagraph (C) that are distributed by an eligible organization to individuals eligible to enroll under this section with the organization, and

(II) any explanation provided to enrollees by the organization pursuant to subparagraph (E).

(4) The organization must—

(A) make the services described in paragraph (2) (and such other health care services as such individuals have contracted for) (i) available and accessible to each such individual, within the area served by the organization, with reasonable promptness and in a manner which assures continuity, and (ii) when medically necessary, available and accessible twenty-four hours a day and seven days a week, and

(B) provide for reimbursement with respect to services which are described in subparagraph (A) and which are provided to such an individual other than through the organization, if (i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition and (ii) it was not reasonable given the circumstances to obtain the services through the organization.

(5)(A) The organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and members enrolled with the organization under this section.

(B) A member enrolled with an eligible organization under this section who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the eligible organization a party. If the amount in controversy is $1,000 or more, the individual or eligible organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the eligible organization shall be entitled to be parties to that judicial review.

(6) The organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals, which program (A) stresses health outcomes and (B) provides review by physicians and other health care professionals of the process followed in the provision of such health care services.

(7) A risk-sharing contract under this section shall provide that in the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

(A) enrollment with an eligible organization under this section—

(i) payment for such services until the date of the individual's discharge shall be made under this title as if the individual were not enrolled with the organization,

(ii) the organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(iii) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this section; or

(B) termination of enrollment with an eligible organization under this section—

(i) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(ii) payment for such services during the stay shall not be made under section 1886(d), and

(iii) the organization shall not receive any payment with respect to the individual under this section during the period the individual is not enrolled.

(8) A contract under this section shall provide that the eligible organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).[1039]

(d) Subject to the provisions of subsection (c)(3), every individual entitled to benefits under part A and enrolled under part B or enrolled under part B only (other than an individual medically determined to have end-stage renal disease) shall be eligible to enroll under this section with any eligible organization with which the Secretary has entered into a contract under this section and which serves the geographic area in which the individual resides.

(e)(1) In no case may—

(A) the portion of an eligible organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under parts A and B) to individuals who are enrolled under this section with the organization and who are entitled to benefits under part A and enrolled under part B, or

(B) the portion of its premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under part B) to individuals who are enrolled under this section with the organization and enrolled under part B only

exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled under this section with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value, the actuarial value of the coinsurance and deductibles applicable on the average to individuals in the area, in the State, or in the United States, eligible to enroll under this section with the organization, or other appropriate data) and entitled to benefits under part A and enrolled under part B, or enrolled under part B only, respectively, if they were not members of an eligible organization.[1040]

[1039] P.L. 101-508, §4206(b)(1), added paragraph (8), applicable to contracts under §1876 and payments under §1833(a)(1)(A) as of December 1, 1991.

See Vol. II, P.L. 101-508, §4206(c), with respect to the effect on State law.

(2) If the eligible organization provides to its members enrolled under this section services in addition to services covered under parts A and B of this title, election of coverage for such additional services (unless such services have been approved by the Secretary under subsection (c)(2)) shall be optional for such members and such organization shall furnish such members with information on the portion of its premium rate or other charges applicable to such additional services. In no case may the sum of—

(A) the portion of such organization's premium rate charged, with respect to such additional services, to members enrolled under this section, and

(B) the actuarial value of its deductibles, coinsurance, and copayments charged, with respect to such services to such members

exceed the adjusted community rate for such services.

(3) For purposes of this section, the term "adjusted community rate" for a service or services means, at the election of an eligible organization, either—

(A) the rate of payment for that service or services which the Secretary annually determines would apply to a member enrolled under this section with an eligible organization if the rate of payment were determined under a "community rating system" (as defined in section 1302(8) of the Public Health Service Act[1041], other than subparagraph (C)), or

(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to a member enrolled under this section with the eligible organization, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the members enrolled with the eligible organization under this section and the utilization characteristics of the other members of the organization (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of members in other eligible organizations, or individuals in the area, in the State, or in the United States, eligible to enroll under this section with an eligible organization and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

(4) Notwithstanding any other provision of law, the eligible organization may (in the case of the provision of services to a member enrolled under this section for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or plan of the United States or a State, under an automobile or liability insurance policy or plan, including a self-insured plan, or under no fault insurance) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

[1040] P.L. 100-360, §202(f)(1), added "The preceding sentence shall be applied separately with respect to covered outpatient drugs.", applicable to enrollments effected on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out that sentence, effective January 1, 1990.

[1041] P.L. 78-410.

(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

(B) such member to the extent that the member has been paid under such law, plan, or policy for such services.

(f)(1) Each eligible organization with which the Secretary enters into a contract under this section shall have, for the duration of such contract, an enrolled membership at least one-half of which consists of individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.

(2) The Secretary may modify or waive the requirement imposed by paragraph (1) only—

(A) to the extent that more than 50 percent of the population of the area served by the organization consists of individuals who are entitled to benefits under this title or under a State plan approved under title XIX, or

(B) in the case of an eligible organization that is owned and operated by a governmental entity, only with respect to a period of three years beginning on the date the organization first enters into a contract under this section, and only if the organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.[1042]

(3) If the Secretary determines that an eligible organization has failed to comply with the requirements of this subsection, the Secretary may provide for the suspension of enrollment of individuals under this section or of payment to the organization under this section for individuals newly enrolled with the organization, after the date the Secretary notifies the organization of such noncompliance.[1043]

(g)(1) The Secretary may enter a risk-sharing contract with any eligible organization, as defined in subsection (b), which has at least 5,000 members, except that the Secretary may enter into such a contract with an eligible organization that has fewer members if the organization primarily serves members residing outside of urbanized areas.

(2) Each risk-sharing contract shall provide that—

(A) if the adjusted community rate, as defined in subsection (e)(3), for services under parts A and B (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for members enrolled under this section with the organization and entitled to benefits under part A and enrolled in part B, or

(B) if the adjusted community rate for services under part B (as reduced for the actuarial value of the coinsurance and deductibles under that part) for members enrolled under this section with the organization and entitled to benefits under part B only

is less than the average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of an annual contract period for members enrolled under this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the eligible organization shall provide to members enrolled under a risk-sharing contract under this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the additional benefits described in paragraph (3) which are selected by the eligible organization and which the Secretary finds are at least equal in value to the difference between that average per capita payment and the adjusted community rate (as so reduced); except that this paragraph shall not apply with respect to any organization which elects to receive a lesser payment to the extent that there is no longer a difference between the average per capita payment and adjusted community rate (as so reduced) and except that an organization (with the approval of the Secretary) may provide that a part of the value of such additional benefits be withheld and reserved by the Secretary as provided in paragraph (5). If the Secretary finds that there is insufficient enrollment experience to determine an average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this section.[1044]

[1042] See Vol. II, P.L. 99-509, §9312(c)(3)(C), with respect to the treatment of current waivers; and (c)(3)(D), with respect to treatment of certain waivers.

[1043] See Vol. II, P.L. 99-509, §9312(c)(3)(C), with respect to treatment of current waivers; and (c)(3)(D), with respect to treatment of certain waivers.

(3) The additional benefits referred to in paragraph (2) are—

(A) the reduction of the premium rate[1045] or other charges made with respect to services furnished by the organization to members enrolled under this section, or

(B) the provision of additional health benefits,

or both.

[(4) Repealed.[1046]]

(5) An organization having a risk-sharing contract under this section may (with the approval of the Secretary[1047]) provide that a part of the value of additional benefits otherwise required to be provided by reason of paragraph (2) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with paragraph (3). Any of such value of additional benefits which is not provided to members of the organization in accordance with paragraph (3) prior to the end of such period, shall revert for the use of such trust funds.[1048]

(6)(A) A risk-sharing contract under this section shall require the eligible organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to such contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

[1044] See Vol. II, P.L. 97-248, §114(d), with respect to a study of additional benefits selected and a report to Congress.

[1045] P.L. 100-360, §202(f)(2), struck out "rate" and substituted "rates", applicable to enrollments effected on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "rates" and substituted "rate", effective January 1, 1990.

[1046] P.L. 100-203, §4012(b); 101 Stat. 1330-61.

[1047] P.L. 101-239, §6212(c)(2), struck out "and during a period of not longer than four years", effective December 19, 1989.

[1048] See Vol. II, P.L. 99-509, §9312(i), with respect to use of reserve funds.

(B) In the case of an eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with subparagraph (A), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individuals enrolled under this section under the contract. If the Secretary provides for such direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this section to reflect the amount of the Secretary's payments (and costs incurred by the Secretary in making such payments).

(h)(1) If—

(A) the Secretary is not satisfied that an eligible organization has the capacity to bear the risk of potential losses under a risk-sharing contract under this section, or

(B) the eligible organization so elects or has an insufficient number of members to be eligible to enter into a risk-sharing contract under subsection (g)(1),

the Secretary may, if he is otherwise satisfied that the eligible organization is able to perform its contractual obligations effectively and efficiently, enter into a contract with such organization pursuant to which such organization is reimbursed on the basis of its reasonable cost (as defined in section 1861(v)) in the manner prescribed in paragraph (3).

(2) A reasonable cost reimbursement contract under this subsection may, at the option of such organization, provide that the Secretary—

(A) will reimburse hospitals and skilled nursing facilities either for the reasonable cost (as determined under section 1861(v)) or for payment amounts determined in accordance with section 1886, as applicable, of services furnished to individuals enrolled with such organization pursuant to subsection (d), and

(B) will deduct the amount of such reimbursement from payment which would otherwise be made to such organization.

If such an eligible organization pays a hospital or skilled nursing facility directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1861(v)) or the amount determined under section 1886, as applicable, unless such organization demonstrates to the satisfaction of the Secretary that such excess payments are justified on the basis of advantages gained by the organization.

(3) Payments made to an organization with a reasonable cost reimbursement contract shall be subject to appropriate retroactive corrective adjustment at the end of each contract year so as to assure that such organization is paid for the reasonable cost actually incurred (excluding any part of incurred cost found to be unnecessary in the efficient delivery of health services) or the amounts otherwise determined under section 1886 for the types of expenses otherwise reimbursable under this title for providing services covered under this title to individuals described in subsection (a)(1).

(4) Any reasonable cost reimbursement contract with an eligible organization under this subsection shall provide that the Secretary shall require, at such time following the expiration of each account-

ing period of the eligible organization (and in such form and in such detail) as he may prescribe—

(A) that the organization report to him in an independently certified financial statement its per capita incurred cost based on the types of components of expenses otherwise reimbursable under this title for providing services described in subsection (a)(1), including therein, in accordance with accounting procedures prescribed by the Secretary, its methods of allocating costs between individuals enrolled under this section and other individuals enrolled with such organization;

(B) that failure to report such information as may be required may be deemed to constitute evidence of likely overpayment on the basis of which appropriate collection action may be taken;

(C) that in any case in which an eligible organization is related to another organization by common ownership or control, a consolidated financial statement shall be filed and that the allowable costs for such organization may not include costs for the types of expense otherwise reimbursable under this title, in excess of those which would be determined to be reasonable in accordance with regulations (providing for limiting reimbursement to costs rather than charges to the eligible organization by related organizations and owners) issued by the Secretary; and

(D) that in any case in which compensation is paid by an eligible organization substantially in excess of what is normally paid for similar services by similar practitioners (regardless of method of compensation), such compensation may as appropriate be considered to constitute a distribution of profits.

(i)(1) Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the eligible organization involved as he may provide in regulations), if he finds that the organization—

(A) has failed substantially to carry out the contract,

(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or

(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).

(2) The effective date of any contract executed pursuant to this section shall be specified in the contract.

(3) Each contract under this section—

(A) shall provide that the Secretary, or any person or organization designated by him—

(i) shall have the right to inspect or otherwise evaluate (I) the quality, appropriateness, and timeliness of services performed under the contract and (II) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

(ii) shall have the right to audit and inspect any books and records of the eligible organization that pertain (I) to the ability of the organization to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;[1049]

(B) shall require the organization with a risk-sharing contract to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled under this section with the organization; and

(C)(i) shall require the organization to comply with subsections (a) and (c) of section 1318 of the Public Health Service Act[1050] (relating to disclosure of certain financial information) and with the requirement of section 1301(c)(8) of such Act (relating to liability arrangements to protect members);

(ii) shall require the organization to provide and supply information (described in section 1866(b)(2)(C)(ii)) in the manner such information is required to be provided or supplied under that section;

(iii) shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties; and

(D) shall contain such other terms and conditions not inconsistent with this section (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

(4) The Secretary may not enter into a risk-sharing contract with an eligible organization if a previous risk-sharing contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

(5) The authority vested in the Secretary by this section may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

(6)(A) If the Secretary determines that an eligible organization with a contract under this section—

(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(ii) imposes premiums on individuals enrolled under this section in excess of the premiums permitted;

(iii) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this section;

(iv) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this section) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(v) misrepresents or falsifies information that is furnished—

(I) to the Secretary under this section, or

[1049] See Vol. II, P.L. 101-234, §203(b), with respect to adjustment of contracts with prepaid health plans.

[1050] P.L. 78-410.

(II) to an individual or to any other entity under this section;[1051]

(vi) fails to comply with the requirements of subsection (g)(6)(A) or paragraph (8)[1052]; or[1053]

(vii) in the case of a risk-sharing contract, employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;[1054]

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in subparagraph (B).

(B) The remedies described in this subparagraph are—

(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A) or, with respect to a determination under clause (iv) or (v)(I) of such subparagraph, of not more than $100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iv), $15,000 for each individual not enrolled as a result of the practice involved,

(ii) suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

(iii) suspension of payment to the organization under this section for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

(7)(A) Each risk-sharing contract with an eligible organization under this section shall provide that the organization will maintain an agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the eligible organization is located) or with an entity selected by the Secretary under section 1154(a)(4)(C) under which the review organization will perform functions under section 1154(a)(4)(B) and section 1154(a)(14) (other than those performed under contracts described in section 1866(a)(1)(F)) with respect to services, furnished by the eligible organization, for which payment may be made under this title.

[1051] P.L. 101-239, §6411(d)(3)(A)(i), struck out "or".

[1052] P.L. 101-508, §4204(a)(2), inserted "or paragraph (8)", applicable to contract years beginning on or after January 1, 1992.

[1053] P.L. 101-239, §6411(d)(3)(A)(ii), added "or".

[1054] P.L. 101-239, §6411(d)(3)(A)(iii), added clause (vii), applicable to employment and contracts as of March 19, 1990.

(B) For purposes of payment under this title, the cost of such agreement to the eligible organization shall be considered a cost incurred by a provider of services in providing covered services under this title and shall be paid directly by the Secretary to the review organization on behalf of such eligible organization in accordance with a schedule established by the Secretary.

(C) Such payments—

(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(ii) shall not be less in the aggregate for such organizations for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting activities described in subparagraph (A) with respect to such eligible organizations under part B of title XI.

(8)(A) Each contract with an eligible organization under this section shall provide that the organization may not operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group, and

(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

(B) In this paragraph, the term "physician incentive plan" means any compensation arrangement between an eligible organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization.[1055]

[1055] P.L. 101-508, §4204(a)(1), added paragraph (8), applicable to contract years beginning on or after January 1, 1992.

(j)(1)(A) In the case of physicians' services or renal dialysis services[1056] described in paragraph (2) which are furnished by a participating physician or provider of services or renal dialysis facility[1057] to an individual enrolled with an eligible organization under this section and enrolled under part B, the applicable participation agreement[1058] is deemed to provide that the physician or provider of services or renal dialysis facility[1059] will accept as payment in full from the eligible organization the amount that would be payable to the physician or provider of services or renal dialysis facility[1060] under part B and from the individual under such part, if the individual were not enrolled with an eligible organization under this section.

(B) In the case of physicians' services described in paragraph (2) which are furnished by a nonparticipating physician, the limitations on actual charges for such services otherwise applicable under part B (to services furnished by individuals not enrolled with an eligible organization under this section) shall apply in the same manner as such limitations apply to services furnished to individuals not enrolled with such an organization.

(2) The physicians' services or renal dialysis services[1061] described in this paragraph are physicians' services or renal dialysis services[1062] which are furnished to an enrollee of an eligible organization under this setion[1063] by a physician, provider of services, or renal dialysis facility who is not under a contract with the organization.[1064]

LIMITATION ON CERTAIN PHYSICIAN REFERRALS[1065]

SEC. 1877. [42 U.S.C. 1395nn] (a) PROHIBITION OF CERTAIN REFERRALS.—

(1) IN GENERAL.—Except as provided in subsection (b), if a physician (or immediate family member of such physician) has a

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[1056] P.L. 101-508, §4204(d)(1)(A)(ii), inserted "or renal dialysis services", applicable to items and services furnished on or after January 1, 1991.

[1057] P.L. 101-508, §4204(d)(1)(A)(i), inserted "or provider of services or renal dialysis facility", applicable to items and services furnished on or after January 1, 1991.

[1058] P.L. 101-508, §4204(d)(1)(A)(iii), struck out "participation agreement under section 1842(h)(1)" and substituted "applicable participation agreement", applicable to items and services furnished on or after January 1, 1991.

[1059] P.L. 101-508, §4204(d)(1)(A)(i), inserted "or provider of services or renal dialysis facility", applicable to items and services furnished on or after January 1, 1991.

[1060] P.L. 101-508, §4204(d)(1)(A)(i), inserted "or provider of services or renal dialysis facility", applicable to items and services furnished on or after January 1, 1991.

[1061] P.L. 101-508, §4204(d)(1)(B)(i), inserted "or renal dialysis services", applicable to items and services furnished on or after January 1, 1991.

[1062] P.L. 101-508, §4204(d)(1)(B)(i), inserted "or renal dialysis services", applicable to items and services furnished on or after January 1, 1991.

[1063] As in original; probably should be "section".

[1064] P.L. 101-239, §6212(b)(1), added subsection (j), applicable to services furnished on or after April 1, 1990.

P.L. 101-508, §4204(d)(1)(B)(ii), struck out a dash and subparagraphs (A) and (B) and substituted "are furnished to an enrollee of an eligible organization under this setion (sic) by a physician, provider of services, or renal dialysis facility who is not under a contract with the organization.", applicable to items and services furnished on or after January 1, 1991. [For subparagraphs (A) and (B) as they formerly read, see Vol. III, P.L. 101-508.]

[1065] P.L. 101-239, §6204(a), added §1877, effective with respect to referrals made on or after January 1, 1992, except the reporting requirement of subsection (f) shall take effect on October 1, 1990.

P.L. 101-239, §6204(d), requires the Secretary to publish final regulations to carry out this section by not later than October 1, 1991*.

*P.L. 101-239, §6204(d) [as amended by P.L. 101-508, §4027(sic)(e)(4)(B)], struck out "1990" and substituted "1991", effective as if included in P.L. 101-239, §6204.

See Vol. II, P.L. 101-239, §6204(f) [as amended by P.L. 101-508, §4027(sic)(e)(4)(A)], with respect to the report the Secretary is required to submit to Congress.

financial relationship with an entity specified in paragraph (2), then—

(A) the physician may not make a referral to the entity for the furnishing of clinical laboratory services for which payment otherwise may be made under this title, and

(B) the entity may not present or cause to be presented a claim under this title or bill to any individual, third party payor, or other entity for clinical laboratory services furnished pursuant to a referral prohibited under subparagraph (A).

(2) FINANCIAL RELATIONSHIP SPECIFIED.—For purposes of this section, a financial relationship of a physician (or immediate family member) with an entity specified in this paragraph is—

(A) except as provided in subsections (c) and (d), an ownership or investment interest in the entity; or

(B) except as provided in subsection (e), a compensation arrangement (as defined in subsection (h)(1)(A)) between the physician (or immediate family member) and the entity.

An ownership or investment interest described in subparagraph (A) may be through equity, debt, or other means.

(b) GENERAL EXCEPTIONS TO BOTH OWNERSHIP AND COMPENSATION ARRANGEMENT PROHIBITIONS.—Subsection (a)(1) shall not apply in the following cases:

(1) PHYSICIANS' SERVICES.—In the case of physicians' services (as defined in section 1861(q)) provided personally by (or under the personal supervision of) another physician in the same group practice (as defined in subsection (h)(4)) as the referring physician.

(2) IN-OFFICE ANCILLARY SERVICES.—In the case of services—

(A) that are furnished—

(i) personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are employed by such physician or group practice and who are personally supervised by the physician or by another physician in the group practice, and

(ii)(I) in a building in which the referring physician (or another physician who is a member of the same group practice) furnishes physicians' services unrelated to the furnishing of clinical laboratory services, or

(II) in the case of a referring physician who is a member of a group practice, in another building which is used by the group practice for the centralized provision of the group's clinical laboratory services, and

(B) that are billed by the physician performing or supervising the services, by a group practice of which such physician is a member, or by an entity that is wholly owned by such physician or such group practice,

if the ownership or investment interest in such services meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(3) PREPAID PLANS.—In the case of services furnished—

(A) by an organization with a contract under section 1876 to an individual enrolled with the organization,

(B) by an organization described in section 1833(a)(1)(A) to an individual enrolled with the organization, or

(C) by an organization receiving payments on a prepaid basis, under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972, to an individual enrolled with the organization.

(4) Hospital financial relationship unrelated to the provision of clinical laboratory services.—In the case of a financial relationship with a hospital if the financial relationship does not relate to the provision of clinical laboratory services.[1066]

(5)[1067] Other permissible exceptions.—In the case of any other financial relationship which the Secretary determines, and specifies in regulations, does not pose a risk of program or patient abuse.

(c) General Exception Related Only to Ownership or Investment Prohibition for Ownership in Publicly-Traded Securities.—Ownership of investment securities (including shares or bonds, debentures, notes, or other debt instruments) which were purchased on terms generally available to the public and which are in a corporation that—

(1) is listed for trading on the New York Stock Exchange or on the American Stock Exchange, or is a national market system security traded under an automated interdealer quotation system operated by the National Association of Securities Dealers, and

(2) had, at the end of the corporation's most recent fiscal year, total assets exceeding $100,000,000,

shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A).

(d) Additional Exceptions Related Only to Ownership or Investment Prohibition.—The following, if not otherwise excepted under subsection (b), shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A):

(1) Hospitals in puerto rico.—In the case of clinical laboratory services provided by a hospital located in Puerto Rico.

(2) Rural provider.—In the case of clinical laboratory services if the laboratory furnishing the services is in a rural area (as defined in section 1886(d)(2)(D)).

(3) Hospital ownership.—In the case of clinical laboratory services provided by a hospital (other than a hospital described in paragraph (1)) if—

(A) the referring physician is authorized to perform services at the hospital, and

(B) the ownership or investment interest is in the hospital itself (and not merely in a subdivision thereof).

(e) Exceptions Relating to Other Compensation Arrangements.—The following shall not be considered to be a compensation arrangement described in subsection (a)(2)(B):

(1) Rental of office space.—Payments made for the rental or lease of office space if—

[1066] P.L. 101-508, §4027(sic)(e)(2), added this paragraph (4), effective as if included in the enactment of §6204 of P.L. 101-239.

[1067] P.L. 101-508, §4027(sic)(e)(2), redesignated paragraph (4) as paragraph (5), effective as if included in the enactment of §6204 of P.L. 101-239.

(A) there is a written agreement, signed by the parties, for the rental or lease of the space, which agreement—

(i) specifies the space covered by the agreement and dedicated for the use of the lessee,

(ii) provides for a term of rental or lease of at least one year;

(iii) provides for payment on a periodic basis of an amount that is consistent with fair market value;

(iv) provides for an amount of aggregate payments that does not vary (directly or indirectly) based on the volume or value of any referrals of business between the parties; and

(v) would be considered to be commercially reasonable even if no referrals were made between the parties;

(B) in the case of rental or lease of office space in which a physician who is an interested investor (or an interested investor who is an immediate family member of the physician) has an ownership or investment interest, the office space is in the same building as the building in which the physician (or group practice of which the physician is a member) has a practice; and

(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(2) EMPLOYMENT AND SERVICE ARRANGEMENTS WITH HOSPITALS.—An arrangement between a hospital and a physician (or immediate family member) for the employment of the physician (or family member) or for the provision of administrative services, if—

(A) the arrangement is for identifiable services;

(B) the amount of the remuneration under the arrangement—

(i) is consistent with the fair market value of the services, and

(ii) is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician;

(C) the remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the hospital; and

(D) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(3) OTHER SERVICE ARRANGEMENTS.—Remuneration from an entity (other than a hospital) under an arrangement if—

(A) the arrangement is—

(i) for specific identifiable services as the medical director or as a member of a medical advisory board at the entity pursuant to a requirement of this title,

(ii) for specific identifiable physicians' services to be furnished to an individual receiving hospice care if payment for such services may only be made under this title as hospice care,

(iii) for specific physicians' services furnished to a nonprofit blood center, or

(iv) for specific identifiable administrative services (other than direct patient care services), but only under exceptional circumstances specified by the Secretary in regulations;

(B) the requirements described in subparagraphs (B) and (C) of paragraph (2) are met with respect to the entity in the same manner as they apply to a hospital; and

(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(4) PHYSICIAN RECRUITMENT.—In the case of remuneration which is provided by a hospital to a physician to induce the physician to relocate to the geographic area served by the hospital in order to be a member of the medical staff of the hospital, if—

(A) the physician is not required to refer patients to the hospital,

(B) the amount of the remuneration under the arrangement is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician, and

(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(5) ISOLATED TRANSACTIONS.—In the case of an isolated financial transaction, such as a one-time sale of property, if—

(A) the requirements described in subparagraphs (B) and (C) of paragraph (2) are met with respect to the entity in the same manner as they apply to a hospital, and

(B) the transaction meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(6) SALARIED PHYSICIANS IN A GROUP PRACTICE.—A compensation arrangement involving payment by a group practice of the salary of a physician member of the group practice.

(f) REPORTING REQUIREMENTS.—Each entity providing covered items or services for which payment may be made under this title shall provide the Secretary with the information concerning the entity's ownership arrangements, including—

(1) the covered items and services provided by the entity, and

(2) the names and unique physician identification numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)) in the entity, or whose immediate relatives have such an ownership or investment.[1068]

Such information shall be provided in such form, manner, and at such times as the Secretary shall specify. Such information shall first be provided not later than October 1, 1991[1069]. The requirement of this subsection shall not apply to covered items and services provided outside the United States or to entities which the Secretary determines provides services for which payment may be made under this title very infrequently.[1070] The Secretary may waive the requirements of this subsection (and the requirements of chapter 35 of title 44, United States Code, with respect to information provided under this subsection) with respect to reporting by entities in a State (except for entities providing clinical laboratory services) so long as such reporting occurs in at least 10 States, and the Secretary may waive such requirements with respect to the providers in a State required to report so long as such requirements are not waived with respect to parenteral and enteral suppliers, end stage renal disease facilities, suppliers of ambulance services, hospitals, entities providing physical therapy services, and entities providing diagnostic imaging services of any type.[1071]

[1068] P.L. 101-508, §4027(sic)(e)(3)(A), amended paragraph (2) in its entirety, effective as if included in the enactment of §6204 of P.L. 101-239. [For paragraph (2) as it formerly read, see Vol. III, P.L. 101-508.]

[1069] P.L. 101-508, §4027(sic)(e)(3)(B), struck out "1 year after the date of the enactment of this section" and substituted "October 1, 1991", effective as if included in the enactment of §6204 of P.L. 101-239.

(g) SANCTIONS.—

(1) DENIAL OF PAYMENT.—No payment may be made under this title for a clinical laboratory service which is provided in violation of subsection (a)(1).

(2) REQUIRING REFUNDS FOR CERTAIN CLAIMS.—If a person collects any amounts that were billed in violation of subsection (a)(1), the person shall be liable to the individual for, and shall refund on a timely basis to the individual, any amounts so collected.

(3) CIVIL MONEY PENALTY AND EXCLUSION FOR IMPROPER CLAIMS.—Any person that presents or causes to be presented a bill or a claim for a service that such person knows or should know is for a service for which payment may not be made under paragraph (1) or for which a refund has not been made under paragraph (2) shall be subject to a civil money penalty of not more than $15,000 for each such service. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(4) CIVIL MONEY PENALTY AND EXCLUSION FOR CIRCUMVENTION SCHEMES.—Any physician or other entity that enters into an arrangement or scheme (such as a cross-referral arrangement) which the physician or entity knows or should know has a principal purpose of assuring referrals by the physician to a particular entity which, if the physician directly made referrals to such entity, would be in violation of this section, shall be subject to a civil money penalty of not more than $100,000 for each such arrangement or scheme. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(5) FAILURE TO REPORT INFORMATION.—Any person who is required, but fails, to meet a reporting requirement of subsection (f) is subject to a civil money penalty of not more than $10,000

[1070] P.L. 101-508, §4027(sic)(e)(3)(C), added this sentence, effective as if included in the enactment of §6204 of P.L. 101-239.

[1071] P.L. 101-508, §4027(sic)(e)(3)(C), added this sentence, effective as if included in the enactment of §6204 of P.L. 101-239.

for each day for which reporting is required to have been made. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).[1072]

(h) DEFINITIONS.—For purposes of this section:

(1) COMPENSATION ARRANGEMENT; REMUNERATION.—(A) The term "compensation arrangement" means any arrangement involving any remuneration between a physician (or immediate family member) and an entity.

(B) The term "remuneration" includes any remuneration, directly or indirectly, overtly or covertly, in cash or in kind.

(2) EMPLOYEE.—An individual is considered to be "employed by" or an "employee" of an entity if the individual would be considered to be an employee of the entity under the usual common law rules applicable in determining the employer-employee relationship (as applied for purposes of section 3121(d)(2) of the Internal Revenue Code of 1986[1073]).

(3) FAIR MARKET VALUE.—The term "fair market value" means the value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.

(4) GROUP PRACTICE.—The term "group practice" means a group of two or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association—

(A) in which each physician who is a member of the group provides substantially the full range of services which the physician routinely provides (including medical care, consultation, diagnosis, or treatment) through the joint use of shared office space, facilities, equipment, and personnel;

(B) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group;

(C) in which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group; and

(D) which meets such other standards as the Secretary may impose by regulation.

In the case of a faculty practice plan associated with a hospital with an approved medical residency training program in which physician members may provide a variety of different specialty services and provide professional services both within and outside the group (as well as perform other tasks such as research), the previous sentence shall be applied only with respect to the services provided within the faculty practice plan.

[1072] P.L. 101-508, §4027(sic)(k)(2), added this sentence, effective November 5, 1990.
[1073] P.L. 83-591.

(5) Interested investor; disinterested investor.—The term "interested investor" means, with respect to an entity, an investor who is a physician in a position to make or to influence referrals or business to the entity (or who is an immediate family member of such an investor), and the term "disinterested investor" means an investor other than an interested investor.

(6) Investor.—The term "investor" means, with respect to an entity, a person with a financial relationship specified in subsection (a)(2) with the entity.[1074]

(7)[1075] Referral; referring physician.—

(A) Physicians' services.—Except as provided in subparagraph (C), in the case of an item or service for which payment may be made under part B, the request by a physician for the item or service,[1076] including the request by a physician for a consultation with another physician (and any test or procedure ordered by, or to be performed by (or under the supervision of) that other physician), constitutes a "referral" by a "referring physician".

(B) Other items.—Except as provided in subparagraph (C),[1077] the request or establishment of a plan of care by a physician which includes the provision of the clinical laboratory service constitutes a "referral" by a "referring physician".

(C) Clarification respecting certain services integral to a consultation by certain specialists.—A request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, if such services are furnished by (or under the supervision of) such pathologist pursuant to a consultation requested by another physician does not constitute a "referral" by a "referring physician".

PROVIDER REIMBURSEMENT REVIEW BOARD

Sec. 1878. [42 U.S.C. 1395oo] (a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) and (except as provided in subsection (g)(2)) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1886 and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1816 as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report, or

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[1074] P.L. 101-508, §4027(sic)(e)(1)(C), inserted this paragraph (6), effective as if included in the enactment of §6204 of P.L. 101-239.

[1075] P.L. 101-508, §4027(sic)(e)(1)(C), redesignated paragraph (6) as paragraph (7).

[1076] P.L. 101-508, §4027(sic)(e)(1)(A), struck out "a clinical laboratory service which under law is required to be provided by (or under the supervision of) a physician, the request by a physician for the service," and substituted "an item or service for which payment may be made under part B, the request by a physician for the item or service,", effective as if included in the enactment of §6204 of P.L. 101-239.

[1077] P.L. 101-508, §4027(sic)(e)(1)(B), struck out "in the case of another clinical laboratory service,", effective as if included in the enactment of §6204 of P.L. 101-239.

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1886,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

(b) The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

(c) At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rules of evidence applicable to court procedure.

(d) A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

(e) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 205 with respect to subpenas shall apply to the Board to the same extent as they apply to the Secretary with respect to title II.

(f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) and equal to the rate of return on equity capital established by regulation pursuant to section 1861(v)(1)(B) and in effect at the time the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this Act.

(g)(1) The finding of a fiscal intermediary that no payment may be made under this title for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1862 shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f).

(2) The determinations and other decisions described in section 1886(d)(7) shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

(h) The Board shall be composed of five members appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of title 5, United States Code. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

(i) The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(j) In this section, the term "provider of services" includes a rural health clinic and[1078] a Federally qualified health center.[1079]

LIMITATION ON LIABILITY OF BENEFICIARY WHERE MEDICARE CLAIMS ARE DISALLOWED[1080]

Sec. 1879. [42 U.S.C. 1395pp] (a) Where—

(1) a determination is made that, by reason of section 1862(a)(1) or (9) or by reason of a coverage denial described in subsection (g)[1081], payment may not be made under part A or part B of this title for any expenses incurred for items or services furnished an individual by a provider of services or by another person pursuant to an assignment under section 1842(b)(3)(B)(ii), and

(2) both such individual and such provider of services or such other person, as the case may be, did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under such part A or part B,

then to the extent permitted by this title, payment shall, notwithstanding such determination, be made for such items or services (and for such period of time as the Secretary finds will carry out the objectives of this title), as though section 1862(a)(1) and section

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[1078] P.L. 101-508, §4161(b)(4), inserted "a rural health clinic and", applicable to cost reports for periods beginning on or after October 1, 1991.

[1079] P.L. 101-508, §4161(a)(6), added subsection (j), applicable to cost reports for periods beginning on or after October 1, 1991.

[1080] See Vol. II, P.L. 97-248, §119, with respect to private sector review initiative and restriction against recovery from beneficiaries.

[1081] P.L. 99-509, §9305(g)(1)(A), inserted "or by reason of a coverage denial described in subsection (g)", applicable to coverage denials occurring on or after July 1, 1987, and before December 31, 1995*.

*P.L. 100-360, §426(c), amended that effective date by striking out "October 1, 1989" and substituting "November 1, 1990", effective July 1, 1988.

P.L. 101-508, §4027(sic)(b)(3), amended that effective date by striking out "November 1, 1990" and substituting "December 31, 1995", effective November 5, 1990.

1862(a)(9) did not apply and as though the coverage denial described in subsection (g) had not occurred[1082]. In each such case the Secretary shall notify both such individual and such provider of services or such other person, as the case may be, of the conditions under which payment for such items or services was made and in the case of comparable situations arising thereafter with respect to such individual or such provider or such other person, each shall, by reason of such notice (or similar notices provided before the enactment of this section[1083]), be deemed to have knowledge that payment cannot be made for such items or services or reasonably comparable items or services. Any provider or other person furnishing items or services for which payment may not be made by reason of section 1862(a)(1) or (9) or by reason of a coverage denial described in subsection (g)[1084] shall be deemed to have knowledge that payment cannot be made for such items or services if the claim relating to such items or services involves a case, provider or other person furnishing services, procedure, or test, with respect to which such provider or other person has been notified by the Secretary (including notification by a utilization and quality control peer review organization) that a pattern of inappropriate utilization has occurred in the past, and such provider or other person has been allowed a reasonable time to correct such inappropriate utilization.[1085]

(b) In any case in which the provisions of paragraphs (1) and (2) of subsection (a) are met, except that such provider or such other person, as the case may be, knew, or could be expected to know, that payment for such services or items could not be made under such part A or part B, then the Secretary shall, upon proper application filed within such time as may be prescribed in regulations, indemnify the individual (referred to in such paragraphs) for any payments received from such individual by such provider or such other person, as the case may be, for such items or services. Any payments made by the Secretary as indemnification shall be deemed to have been made to such provider or such other person, as the case may be, and shall be treated as overpayments, recoverable from such provider or such other person, as the case may be, under applicable provisions of law. In each such case the Secretary shall notify such individual of the conditions under which indemnification is made and in the case of comparable situations arising thereafter with respect to such individual, he shall, by reason of such notice (or similar notices provided before the enactment of this section[1086]), be deemed to have knowledge that payment cannot be made for such items or services. No item or service for which an individual is indemnified under this subsection shall be taken into account in applying any limitation on the amount of items and services for which payment may be made to or on behalf of the individual under this title.

[1082] P.L. 99-509, §9305(g)(1)(B), inserted "and as though the coverage denial described in subsection (g) had not occurred", applicable to coverage denials occurring on or after July 1, 1987, and before December 31, 1995*.

*P.L. 100-360, §426(c), amended that effective date by striking out "October 1, 1989" and substituting "November 1, 1990", effective July 1, 1988.

P.L. 101-508, §4027(sic)(b)(3), amended that effective date by striking out "November 1, 1990" and substituting "December 31, 1995", effective November 5, 1990.

[1083] October 30, 1972 [P.L. 92-603; 86 Stat. 1385].

[1084] P.L. 99-509, §9305(g)(1)(C), inserted "or by reason of a coverage denial described in subsection (g)", applicable to coverage denials occurring on or after July 1, 1987, and before December 31, 1995*.

*P.L. 100-360, §426(c), amended that effective date by striking out "October 1, 1989" and substituting "November 1, 1990", effective July 1, 1988.

P.L. 101-508, §4027(sic)(b)(3), amended that effective date by striking out "November 1, 1990" and substituting "December 31, 1995", effective November 5, 1990.

[1085] See Vol. II, P.L. 99-509, §9305(f), with respect to extension of waiver of liability provisions to hospice programs.

[1086] October 30, 1972 [P.L. 92-603; 86 Stat. 1385].

(c) No payments shall be made under this title in any cases in which the provisions of paragraph (1) of subsection (a) are met, but both the individual to whom the items or services were furnished and the provider of service or other person, as the case may be, who furnished the items or services knew, or could reasonably have been expected to know, that payment could not be made for items or services under part A or part B by reason of section 1862(a)(1) or (a)(9) or by reason of a coverage denial described in subsection (g)[1087].

(d) In any case arising under subsection (b) (but without regard to whether payments have been made by the individual to the provider or other person) or subsection (c), the provider or other person shall have the same rights that an individual has under sections 1869(b) and 1842(b)(3)(C) (as may be applicable) when the amount of benefit or payments is in controversy, except that such rights may, under prescribed regulations, be exercised by such provider or other person only after the Secretary determines that the individual will not exercise such rights under such sections.

(e) Where payment for inpatient hospital services or extended care services may not be made under part A of this title on behalf of an individual entitled to benefits under such part solely because of an unintentional, inadvertent, or erroneous action with respect to the transfer of such individual from a hospital or skilled nursing facility that meets the requirements of section 1861(e) or (j) by such a provider of services acting in good faith in accordance with the advice of a utilization review committee, quality control and peer review organization, or fiscal intermediary, or on the basis of a clearly erroneous administrative decision by a provider of services, the Secretary shall take such action with respect to the payment of such benefits as he determines may be necessary to correct the effects of such unintentional, inadvertent, or erroneous action.

(f)(1) A home health agency which meets the applicable requirements of paragraphs (3) and (4) shall be presumed to meet the requirement of subsection (a)(2)[1088].

(2) The presumption of paragraph (1) with respect to specific services may be rebutted by actual or imputed knowledge of the facts described in subsection (a)(2), including any of the following:

(A) Notice by the fiscal intermediary of the fact that payment may not be made under this title with respect to the services.

(B) It is clear and obvious that the provider should have known at the time the services were furnished that they were excluded from coverage.

(3) The requirements of this paragraph are as follows:

[1087] P.L. 99-509, §9305(g)(1)(D), inserted "or by reason of a coverage denial described in subsection (g)", applicable to coverage denials occurring on or after July 1, 1987, and before December 31, 1995[*].

[*] P.L. 100-360, §426(c), amended that effective date by striking out "October 1, 1989" and substituting "November 1, 1990", effective July 1, 1988.

P.L. 101-508, §4027(sic)(b)(3), amended that effective date by striking out "November 1, 1990" and substituting "December 31, 1995", effective November 5, 1990.

[1088] P.L. 101-239, §6214(a)(1), struck out "with respect to any coverage denial described in subsection (g)", applicable to determinations for quarters beginning on or after December 19, 1989.

(A) The agency complies with requirements of the Secretary under this title respecting timely submittal of bills for payment and medical documentation.

(B) The agency program has reasonable procedures to notify promptly each patient (and the patient's physician) where it is determined that a patient is being or will be furnished items or services which are excluded from coverage under this title.

(4)(A)[1089] The requirement of this paragraph is that, on the basis of bills submitted by a home health agency during the previous quarter, the rate of denial of bills for the agency by reason of a coverage denial described in subsection (g) does not exceed 2.5 percent, computed based on visits for home health services billed.

(B) For purposes of determining the rate of denial of bills for a home health agency under subparagraph (A), a bill shall not be considered to be denied until the expiration of the 60-day period that begins on the date such bill is denied by the fiscal intermediary, or, with respect to such a denial for which the agency requests reconsideration, until the fiscal intermediary issues a decision denying payment for such bill.[1090]

(5) In this subsection, the term "fiscal intermediary" means, with respect to a home health agency, an agency or organization with an agreement under section 1816 with respect to the agency.[1091]

(6) The Secretary shall monitor the proportion of denied bills submitted by home health agencies for which reconsideration is requested, and shall notify Congress if the proportion of denials reversed upon reconsideration increases significantly.[1092]

(g) The coverage denial described in this subsection is, with respect to the provision of home health services to an individual, a failure to meet the requirements of section 1814(a)(2)(C) or section 1835(a)(2)(A) in that the individual—

(1) is or was not confined to his home, or

(2) does or did not need skilled nursing care on an intermittent basis.[1093]

INDIAN HEALTH SERVICE FACILITIES[1094]

SEC. 1880. [42 U.S.C. 1395qq] (a) A hospital or skilled nursing facility of the Indian Health Service, whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act[1095]), shall be eligible for payments under this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as it meets all of the conditions and requirements for such payments which are applicable generally to hospitals or skilled nursing facilities (as the case may be) under this title.

[1089] P.L. 101-239, §6214(a)(2), inserted "(A)".

[1090] P.L. 101-239, §6214(a)(2), added subparagraph (B), applicable to determinations for quarters beginning on or after December 19, 1989.

[1091] P.L. 99-509, §9305(g)(1)(E), added this subsection, applicable to coverage denials occurring on or after July 1, 1987, and before December 31, 1995*.

*P.L. 100-360, §426(c), amended that effective date by striking out "October 1, 1989" and substituting "November 1, 1990", effective July 1, 1988.

P.L. 101-508, §4027(sic)(b)(3), amended that effective date by striking out "November 1, 1990" and substituting "December 31, 1995", effective November 5, 1990.

[1092] P.L. 101-239, §6214(b), added paragraph (6), effective December 19, 1989.

[1093] P.L. 99-509, §9305(g)(1)(E), added this subsection, applicable to coverage denials occurring on or after July 1, 1987, and before December 31, 1995*.

*P.L. 100-360, §426(c), amended that effective date by striking out "October 1, 1989" and substituting "November 1, 1990", effective July 1, 1988.

P.L. 101-508, §4027(sic)(b)(3), amended that effective date by striking out "November 1, 1990" and substituting "December 31, 1995", effective November 5, 1990.

[1094] See Vol. II, P.L. 94-437, §401(c) with respect to appropriations, and §401(d) with respect to equality of right to coverage.

[1095] P.L. 94-437.

(b) Notwithstanding subsection (a), a hospital or skilled nursing facility of the Indian Health Service which does not meet all of the conditions and requirements of this title which are applicable generally to hospitals or skilled nursing facilities (as the case may be), but which submits to the Secretary within six months after the date of the enactment of this section[1096] an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for payments under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.

(c) Notwithstanding any other provision of this title, payments to which any hospital or skilled nursing facility of the Indian Health Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the hospitals and skilled nursing facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of this title. The preceding sentence shall cease to apply when the Secretary determines and certifies that substantially all of the hospitals and skilled nursing facilities of such Service in the United States are in compliance with such conditions and requirements.[1097]

(d) The annual report of the Secretary which is required by section 701 of the Indian Health Care Improvement Act shall include (along with the matters specified in section 403 of such Act) a detailed statement of the status of the hospitals and skilled nursing facilities of the Service in terms of their compliance with the applicable conditions and requirements of this title and of the progress being made by such hospitals and facilities (under plans submitted under subsection (b) and otherwise) toward the achievement of such compliance.

MEDICARE COVERAGE FOR END STAGE RENAL DISEASE PATIENTS[1098]

SEC. 1881. [42 U.S.C. 1395rr] (a) The benefits provided by parts A and B of this title shall include benefits for individuals who have been determined to have end stage renal disease as provided in section 226A, and benefits for kidney donors as provided in subsection (d) of this section. Notwithstanding any other provision of this title, the type, duration, and scope of the benefit provided by parts A and B with respect to individuals who have been determined to have end stage renal disease and who are entitled to such benefits without regard to section 226A shall in no case be less than the type, duration, and scope of the benefits so provided for individuals entitled to such benefits solely by reason of that section.

[1096] September 30, 1976 [P.L. 94-437; 90 Stat. 1400].

[1097] See Vol. II, P.L. 94-437, §405, with respect to a demonstration program for direct billing of medicare, medicaid, and other third party payors; and §713(b)(2)(A), with respect to medicare and medicaid reimbursements.

[1098] See Vol. II, P.L. 99-272, §9217, with respect to liver transplants.

See Vol. II, P.L. 100-203, §4036(d)(1)-(4), with respect to a study to be made of the end-stage renal disease program and a report to Congress.

(b)(1) Payments under this title with respect to services, in addition to services for which payment would otherwise be made under this title, furnished to individuals who have been determined to have end stage renal disease shall include (A) payments on behalf of such individuals to providers of services and renal dialysis facilities which meet such requirements as the Secretary shall by regulation prescribe for institutional dialysis services and supplies (including self-dialysis services in a self-care dialysis unit maintained by the provider or facility), transplantation services, self-care home dialysis support services which are furnished by the provider or facility, and routine professional services performed by a physician during a maintenance dialysis episode if payments for his other professional services furnished to an individual who has end stage renal disease are made on the basis specified in paragraph (3)(A) of this subsection, (B)[1099] payments to or on behalf of such individuals for home dialysis supplies and equipment, and (C) payments to a supplier of home dialysis supplies and equipment that is not a provider of services, a renal dialysis facility, or a physician for self-administered erythropoietin as described in section 1861(s)(2)(Q) if the Secretary finds that the patient receiving such drug from such a supplier can safely and effectively administer the drug (in accordance with the applicable methods and standards established by the Secretary pursuant to such section).[1100] The requirements prescribed by the Secretary under subparagraph (A) shall include requirements for a minimum utilization rate for transplantations.

(2)(A) With respect to payments for dialysis services furnished by providers of services and renal dialysis facilities to individuals determined to have end stage renal disease for which payments may be made under part B of this title, such payments (unless otherwise provided in this section) shall be equal to 80 percent of the amounts determined in accordance with subparagraph (B); and with respect to payments for services for which payments may be made under part A of this title, the amounts of such payments (which amounts shall not exceed, in respect to costs in procuring organs attributable to payments made to an organ procurement agency or histocompatibility laboratory, the costs incurred by that agency or laboratory) shall be determined in accordance with section 1861(v) or section 1886 (if applicable). Payments shall be made to a renal dialysis facility only if it agrees to accept such payments as payment in full for covered services, except for payment by the individual of 20 percent of the estimated amounts for such services calculated on the basis established by the Secretary under subparagraph (B) and the deductible amount imposed by section 1833(b).

(B) The Secretary shall prescribe in regulations any methods and procedures to (i) determine the costs incurred by providers of services and renal dialysis facilities in furnishing covered services to individuals determined to have end stage renal disease, and (ii) determine, on a cost-related basis or other economical and equitable basis (including any basis authorized under section 1861(v)) and consistent with any regulations promulgated under paragraph (7), the amounts of payments to be made for part B services furnished by such providers and facilities to such individuals.

[1099] P.L. 101-508, §4201(d)(2)(A)(B)(sic), struck out "and (B)" and substituted "(B)", applicable to items and services furnished on or after July 1, 1991.

[1100] P.L. 101-508, §4201(d)(2)(A)(C)(sic), struck out "equipment." and substituted "equipment, and (C) payments to a supplier of home dialysis supplies and equipment that is not a provider of services, a renal dialysis facility, or a physician for self-administered erythropoietin as described in section 1861(s)(2)(Q) if the Secretary finds that the patient receiving such drug from such a supplier can safely and effectively administer the drug (in accordance with the applicable methods and standards established by the Secretary pursuant to such section).", applicable to items and services furnished on or after July 1, 1991.

(C) Such regulations, in the case of services furnished by proprietary providers and facilities (other than hospital outpatient departments) may include, if the Secretary finds it feasible and appropriate, provision for recognition of a reasonable rate of return on equity capital, providing such rate of return does not exceed the rate of return stipulated in section 1861(v)(1)(B).

(D) For purposes of section 1878, a renal dialysis facility shall be treated as a provider of services.

(3) With respect to payments for physicians' services furnished to individuals determined to have end stage renal disease, the Secretary shall pay 80 percent of the amounts calculated for such services—

(A) on a reasonable charge basis (but may, in such case, make payment on the basis of the prevailing charges of other physicians for comparable services or, for services furnished on or after January 1, 1992, on the basis described in section 1848[1101]) except that payment may not be made under this subparagraph for routine services furnished during a maintenance dialysis episode, or

(B) on a comprehensive monthly fee or other basis (which effectively encourages the efficient delivery of dialysis services and provides incentives for the increased use of home dialysis) for an aggregate of services provided over a period of time (as defined in regulations).

(4)(A)[1102] Pursuant to agreements with approved providers of services and renal dialysis facilities, the Secretary may make payments to such providers and facilities for the cost of home dialysis supplies and equipment and self-care home dialysis support services furnished to patients whose self-care home dialysis is under the direct supervision of such provider or facility, on the basis of a target reimbursement rate (as defined in paragraph (6)) or on the basis of a method established under paragraph (7).

(B) The Secretary shall make payments to a supplier of home dialysis supplies and equipment furnished to a patient whose self-care home dialysis is not under the direct supervision of an approved provider of services or renal dialysis facility only in accordance with a written agreement under which—

(i) the patient certifies that the supplier is the sole provider of such supplies and equipment to the patient,

(ii) the supplier agrees to receive payment for the cost of such supplies and equipment only on an assignment-related basis, and

(iii) the supplier certifies that it has entered into a written agreement with an approved provider of services or renal dialysis facility under which such provider or facility agrees to furnish to such patient all self-care home dialysis support services and all other necessary dialysis services and supplies, including institutional dialysis services and supplies and emergency services.[1103]

[1101] P.L. 101-239, §6102(e)(8), inserted "or, for services furnished on or after January 1, 1992, on the basis described in section 1848", effective December 19, 1989.

[1102] P.L. 101-239, §6203(b)(2)(A), inserted "(A)".

(5) An agreement under paragraph (4) shall require, in accordance with regulations prescribed by the Secretary, that the provider or facility will—

(A) assume full responsibility for directly obtaining or arranging for the provision of—

(i) such medically necessary dialysis equipment as is prescribed by the attending physician;

(ii) dialysis equipment maintenance and repair services;

(iii) the purchase and delivery of all necessary medical supplies; and

(iv) where necessary, the services of trained home dialysis aides;

(B) perform all such administrative functions and maintain such information and records as the Secretary may require to verify the transactions and arrangements described in subparagraph (A);

(C) submit such cost reports, data, and information as the Secretary may require with respect to the costs incurred for equipment, supplies, and services furnished to the facility's home dialysis patient population; and

(D) provide for full access for the Secretary to all such records, data, and information as he may require to perform his functions under this section.

(6) The Secretary shall establish, for each calendar year, commencing with January 1, 1979, a target reimbursement rate for home dialysis which shall be adjusted for regional variations in the cost of providing home dialysis. In establishing such a rate, the Secretary shall include—

(A) the Secretary's estimate of the cost of providing medically necessary home dialysis supplies and equipment;

(B) an allowance, in an amount determined by the Secretary, to cover the cost of providing personnel to aid in home dialysis; and

(C) an allowance, in an amount determined by the Secretary, to cover administrative costs and to provide an incentive for the efficient delivery of home dialysis;

but in no event (except as may be provided in regulations under paragraph (7)) shall such target rate exceed 75 percent of the national average payment, adjusted for regional variations, for maintenance dialysis services furnished in approved providers and facilities during the preceding fiscal year. Any such target rate so established shall be utilized, without renegotiation of the rate, throughout the calendar year for which it is established. During the last quarter of each calendar year, the Secretary shall establish a home dialysis target reimbursement rate for the next calendar year based on the most recent data available to the Secretary at the time. In establishing any rate under this paragraph, the Secretary may utilize a competitive-bid procedure, a prenegotiated rate procedure, or any other procedure (including methods established under paragraph (7)) which the Secretary determines is appropriate and feasible in order to carry out this paragraph in an effective and efficient manner.

[1103] P.L. 101-239, §6203(b)(2)(B), added subparagraph (B), applicable to dialysis services, supplies, and equipment furnished on or after February 1, 1990.

(7) The Secretary shall provide by regulation for a method (or methods) for determining prospectively the amounts of payments to be made for dialysis services furnished by providers of services and renal dialysis facilities to individuals in a facility and to such individuals at home. Such method (or methods) shall provide for the prospective determination of a rate (or rates) for each mode of care based on a single composite weighted formula (which takes into account the mix of patients who receive dialysis services at a facility or at home and the relative costs of providing such services in such settings) for hospital-based facilities and such a single composite weighted formula for other renal dialysis facilities, or based on such other method or combination of methods which differentiate between hospital-based facilities and other renal dialysis facilities and which the Secretary determines, after detailed analysis, will more effectively encourage the more efficient delivery of dialysis services and will provide greater incentives for increased use of home dialysis than through the single composite weighted formulas. The amount of a payment made under any method other than a method based on a single composite weighted formula may not exceed the amount (or, in the case of continuous cycling peritoneal dialysis, 130 percent of the amount) of the median payment that would have been made under the formula for hospital-based facilities.[1104] The Secretary shall provide for such exceptions to such methods as may be warranted by unusual circumstances (including the special circumstances of sole facilities located in isolated, rural areas and of pediatric facilities). Each application for such an exception shall be deemed to be approved unless the Secretary disapproves it by not later than 60 working days after the date the application is filed. The Secretary may provide that such method will serve in lieu of any target reimbursement rate that would otherwise be established under paragraph (6). The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the organizations (designated under subsection (c)(1)(A)) for such organizations' necessary and proper administrative costs incurred in carrying out the responsibilities described in subsection (c)(2).[1105] The Secretary shall provide that amounts paid under the previous sentence shall be distributed to the organizations described in subsection (c)(1)(A) to ensure equitable treatment of all such network organizations.[1106] The Secretary in distributing any such payments to network organizations shall take into account—

(A) the geographic size of the network area;

(B) the number of providers of end stage renal disease services in the network area;

[1104] P.L. 101-239, §6203(b)(1), inserted this sentence, applicable to dialysis services, supplies, and equipment furnished on or after February 1, 1990.

[1105] P.L. 101-239, §6219(a), struck out "network administrative organization (designated under subsection (c)(1)(A) for the network area in which the treatment is provided) for its necessary and proper administrative costs incurred in carrying out its responsibilities under subsection (c)(2)." and substituted "organizations (designated under subsection (c)(1)(A)) for such organizations' necessary and proper administrative costs incurred in carrying out the responsibilities described in subsection (c)(2).", effective December 19, 1989.

[1106] P.L. 101-239, §6219(a), added this sentence, effective December 19, 1989.

(C) the number of individuals who are entitled to end stage renal disease services in the network area; and

(D) the proportion of the aggregate administrative funds collected in the network area.[1107]

(8) For purposes of this title, the term "home dialysis supplies and equipment" means medically necessary supplies and equipment (including supportive equipment) required by an individual suffering from end stage renal disease in connection with renal dialysis carried out in his home (as defined in regulations), including obtaining, installing, and maintaining such equipment.

(9) For purposes of this title, the term "self-care home dialysis support services", to the extent permitted in regulation, means—

(A) periodic monitoring of the patient's home adaptation, including visits by qualified provider or facility personnel (as defined in regulations), so long as this is done in accordance with a plan prepared and periodically reviewed by a professional team (as defined in regulations) including the individual's physician;

(B) installation and maintenance of dialysis equipment;

(C) testing and appropriate treatment of the water; and

(D) such additional supportive services as the Secretary finds appropriate and desirable.

(10) For purposes of this title, the term "self-care dialysis unit" means a renal dialysis facility or a distinct part of such facility or of a provider of services, which has been approved by the Secretary to make self-dialysis services, as defined by the Secretary in regulations, available to individuals who have been trained for self-dialysis. A self-care dialysis unit must, at a minimum, furnish the services, equipment and supplies needed for self-care dialysis, have patient-staff ratios which are appropriate to self-dialysis (allowing for such appropriate lesser degree of ongoing medical supervision and assistance of ancillary personnel than is required for full care maintenance dialysis), and meet such other requirements as the Secretary may prescribe with respect to the quality and cost-effectiveness of services.

(11)(A)[1108] Hepatitis B vaccine and its administration, when provided to a patient determined to have end stage renal disease, shall not be included as dialysis services for purposes of payment under any prospective payment amount or comprehensive fee established under this section. Payment for such vaccine and its administration shall be made separately in accordance with section 1833.

(B) Erythropoietin, when provided to a patient determined to have end stage renal disease, shall not be included as a dialysis service for purposes of payment under any prospective payment amount or comprehensive fee established under this section, and payment for such item shall be made separately—

(i) in the case of erythropoietin provided by a physician, in accordance with section 1833; and

(ii) in the case of erythropoietin provided by a provider of services, renal dialysis facility, or other supplier of home dialysis supplies and equipment—

[1107] P.L. 101-239, §6219(a), added this sentence, effective December 19, 1989.

See Vol. II, P.L. 99-509, §9335(a)(1) [as amended by P.L. 101-239, §6203(a)(1), and P.L. 101-508, §4201(a)(2)], with respect to establishment of the base rate.

[1108] P.L. 101-508, §4201(c)(1)(A), redesignated paragraph (11) as subparagraph (11)(A), applicable to erythropoietin furnished on or after January 1, 1991.

(I) for erythropoietin provided during 1991, in an amount equal to $11 per thousand units (rounded to the nearest 100 units), and

(II) for erythropoietin provided during a subsequent year, in an amount determined to be appropriate by the Secretary, except that such amount may not exceed the amount determined under this clause for the previous year increased by the percentage increase (if any) in the implicit price deflator for gross national product (as published by the Department of Commerce) for the second quarter of the preceding year over the implicit price deflator for the second quarter of the second preceding year.[1109]

(C) The amount payable to a supplier of home dialysis supplies and equipment that is not a provider of services, a renal dialysis facility, or a physician for erythropoietin shall be determined in the same manner as the amount payable to a renal dialysis facility for such item.[1110]

(c)(1)(A)(i) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall, in accordance with such criteria as he finds necessary to assure the performance of the responsibilities and functions specified in paragraph (2)—

(I) establish at least 17 end stage renal disease network areas, and

(II) for each such area, designate a network administrative organization which, in accordance with regulations of the Secretary, shall establish (aa) a network council of renal dialysis and transplant facilities located in the area and (bb) a medical review board, which has a membership including at least one patient representative and physicians, nurses, and social workers engaged in treatment relating to end stage renal disease.

The Secretary shall publish in the Federal Register a description of the geographic area that he determines, after consultation with appropriate professional and patient organizations, constitutes each network area and the criteria on the basis of which such determination is made.

(ii)(I) In order to determine whether the Secretary should enter into, continue, or terminate an agreement with a network administrative organization designated for an area established under clause (i), the Secretary shall develop and publish in the Federal Register standards, criteria, and procedures to evaluate an applicant organization's capabilities to perform (and, in the case of an organization with which such an agreement is in effect, actual performance of) the responsibilities described in paragraph (2). The Secretary shall evaluate each applicant based on quality and scope of services and may not accord more than 20 percent of the weight of the evaluation to the element of price.

(II) An agreement with a network administrative organization may be terminated by the Secretary only if he finds, after applying such standards and criteria, that the organization has failed to perform its prescribed responsibilities effectively and efficiently. If such an agreement is to be terminated, the Secretary shall select a successor to the agreement on the basis of competitive bidding and in a manner that provides an orderly transition.

[1109] P.L. 101-508, §4201(c)(1)(B), added subparagraph (B), applicable to erythropoietin furnished on or after January 1, 1991.

[1110] P.L. 101-508, §4201(d)(3), added subparagraph (C), applicable to items and services furnished on or after July 1, 1991.

(B) At least one patient representative shall serve as a member of each network council and each medical review board.

(C) The Secretary shall, in regulations, prescribe requirements with respect to membership in network organizations by individuals (and the relatives of such individuals) (i) who have an ownership or control interest in a facility or provider which furnishes services referred to in section 1861(s)(2)(F), or (ii) who have received remuneration from any such facility or provider in excess of such amounts as constitute reasonable compensation for services (including time and effort relative to the provision of professional medical services) or goods supplied to such facility or provider; and such requirements shall provide for the definition, disclosure, and, to the maximum extent consistent with effective administration, prevention of potential or actual financial or professional conflicts of interest with respect to decisions concerning the appropriateness, nature, or site of patient care.

(2) The network organizations of each network shall be responsible, in addition to such other duties and functions as may be prescribed by the Secretary, for—

(A) encouraging, consistent with sound medical practice, the use of those treatment settings most compatible with the successful rehabilitation of the patient and the participation of patients, providers of services, and renal disease facilities in vocational rehabilitation programs;

(B) developing criteria and standards relating to the quality and appropriateness of patient care and with respect to working with patients, facilities, and providers in encouraging participation in vocational rehabilitation programs; and network goals with respect to the placement of patients in self-care settings and undergoing or preparing for transplantation;

(C) evaluating the procedure by which facilities and providers in the network assess the appropriateness of patients for proposed treatment modalities;

(D) implementing a procedure for evaluating and resolving patient grievances;

(E) conducting on-site reviews of facilities and providers as necessary (as determined by a medical review board or the Secretary), utilizing standards of care established by the network organization to assure proper medical care;

(F) collecting, validating, and analyzing such data as are necessary to prepare the reports required by subparagraph (H) and to assure the maintenance of the registry established under paragraph (7);

(G) identifying facilities and providers that are not cooperating toward meeting network goals and assisting such facilities and providers in developing appropriate plans for correction and reporting to the Secretary on facilities and providers that are not providing appropriate medical care; and

(H) submitting an annual report to the Secretary on July 1 of each year which shall include a full statement of the network's goals, data on the network's performance in meeting its goals (including data on the comparative performance of facilities and providers with respect to the identification and placement of suitable candidates in self-care settings and transplantation and encouraging participation in vocational rehabilitation programs), identification of those facilities that have consistently failed to cooperate with network goals, and recommendations with respect to the need for additional or alternative services or facilities in the network in order to meet the network goals, including self-dialysis training, transplantation, and organ procurement facilities.

(3) Where the Secretary determines, on the basis of the data contained in the network's annual report and such other relevant data as may be available to him, that a facility or provider has consistently failed to cooperate with network plans and goals or to follow the recommendations of the medical review board, he may terminate or withhold certification of such facility or provider (for purposes of payment for services furnished to individuals with end stage renal disease) until he determines that such provider or facility is making reasonable and appropriate efforts to cooperate with the network's plans and goals. If the Secretary determines that the facility's or provider's failure to cooperate with network plans and goals does not jeopardize patient health or safety or justify termination of certification, he may instead, after reasonable notice to the provider or facility and to the public, impose such other sanctions as he determines to be appropriate, which sanctions may include denial of reimbursement with respect to some or all patients admitted to the facility after the date of notice to the facility or provider, and graduated reduction in reimbursement for all patients.

(4) The Secretary shall, in determining whether to certify additional facilities or expansion of existing facilities within a network, take into account the network's goals and performance as reflected in the network's annual report.

(5) The Secretary, after consultation with appropriate professional and planning organizations, shall provide such guidelines with respect to the planning and delivery of renal disease services as are necessary to assist network organizations in their development of their respective networks' goals to promote the optimum use of self-dialysis and transplantation by suitable candidates for such modalities.

(6) It is the intent of the Congress that the maximum practical number of patients who are medically, socially, and psychologically suitable candidates for home dialysis or transplantation should be so treated and that the maximum practical number of patients who are suitable candidates for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment. The Secretary shall consult with appropriate professional and network organizations and consider available evidence relating to developments in research, treatment methods, and technology for home dialysis and transplantation.

(7) The Secretary shall establish a national end stage renal disease registry the purpose of which shall be to assemble and analyze the data reported by network organizations, transplant centers, and other sources on all end stage renal disease patients in a manner that will permit—

(A) the preparation of the annual report to the Congress required under subsection (g);

(B) an identification of the economic impact, cost-effectiveness, and medical efficacy of alternative modalities of treatment;

(C) an evaluation with respect to the most appropriate allocation of resources for the treatment and research into the cause of end stage renal disease;

(D) the determination of patient mortality and morbidity rates, and trends in such rates, and other indices of quality of care; and

(E) such other analyses relating to the treatment and management of end stage renal disease as will assist the Congress in evaluating the end stage renal disease program under this section.

The Secretary shall provide for such coordination of data collection activities, and such consolidation of existing end stage renal disease data systems, as is necessary to achieve the purpose of such registry, shall determine the appropriate location of the registry, and shall provide for the appointment of a professional advisory group to assist the Secretary in the formulation of policies and procedures relevant to the management of such registry.

(8) The provisions of sections 1157 and 1160 shall apply with respect to network administrative organizations (including such organizations as medical review boards) with which the Secretary has entered into agreements under this subsection.[1111]

(d) Notwithstanding any provision to the contrary in section 226 any individual who donates a kidney for transplant surgery shall be entitled to benefits under parts A and B of this title with respect to such donation. Reimbursement for the reasonable expenses incurred by such an individual with respect to a kidney donation shall be made (without regard to the deductible, premium, and coinsurance provisions of this title), in such manner as may be prescribed by the Secretary in regulations, for all reasonable preparatory, operation, and postoperation recovery expenses associated with such donation, including but not limited to the expenses for which payment could be made if he were an eligible individual for purposes of parts A and B of this title without regard to this subsection. Payments for postoperation recovery expenses shall be limited to the actual period of recovery.

(e)(1) Notwithstanding any other provision of this title, the Secretary may, pursuant to agreements with approved providers of services, renal dialysis facilities, and nonprofit entities which the Secretary finds can furnish equipment economically and efficiently, reimburse such providers, facilities, and nonprofit entities (without regard to the deductible and coinsurance provisions of this title) for the reasonable cost of the purchase, installation, maintenance and reconditioning for subsequent use of artificial kidney and automated dialysis peritoneal machines (including supportive equipment) which are to be used exclusively by entitled individuals dialyzing at home.

(2) An agreement under this subsection shall require that the provider, facility, or other entity will—

(A) make the equipment available for use only by entitled individuals dialyzing at home;

[1111] P.L. 101-239, §6219(b), added paragraph (8), effective December 19, 1989.

(B) recondition the equipment, as needed, for reuse by such individuals throughout the useful life of the equipment, including modification of the equipment consistent with advances in research and technology;

(C) provide for full access for the Secretary to all records and information relating to the purchase, maintenance, and use of the equipment; and

(D) submit such reports, data, and information as the Secretary may require with respect to the cost, management, and use of the equipment.

(3) For purposes of this section, the term "supportive equipment" includes blood pumps, heparin pumps, bubble detectors, other alarm systems, and such other items as the Secretary may determine are medically necessary.

(f)(1) The Secretary shall initiate and carry out, at selected locations in the United States, pilot projects under which financial assistance in the purchase of new or used durable medical equipment for renal dialysis is provided to individuals suffering from end stage renal disease at the time home dialysis is begun, with provision for a trial period to assure successful adaptation to home dialysis before the actual purchase of such equipment.

(2) The Secretary shall conduct experiments to evaluate methods for reducing the costs of the end stage renal disease program. Such experiments shall include (without being limited to) reimbursement for nurses and dialysis technicians to assist with home dialysis, and reimbursement to family members assisting with home dialysis.

(3) The Secretary shall conduct experiments to evaluate methods of dietary control for reducing the costs of the end stage renal disease program, including (without being limited to) the use of protein-controlled products to delay the necessity for, or reduce the frequency of, dialysis in the treatment of end stage renal disease.

(4) The Secretary shall conduct a comprehensive study of methods for increasing public participation in kidney donation and other organ donation programs.

(5) The Secretary shall conduct a full and complete study of the reimbursement of physicians for services furnished to patients with end stage renal disease under this title, giving particular attention to the range of payments to physicians for such services, the average amounts of such payments, and the number of hours devoted to furnishing such services to patients at home, in renal disease facilities, in hospitals, and elsewhere.

(6) The Secretary shall conduct a study of the number of patients with end stage renal disease who are not eligible for benefits with respect to such disease under this title (by reason of this section or otherwise), and of the economic impact of such noneligibility of such individuals. Such study shall include consideration of mechanisms whereby governmental and other health plans might be instituted or modified to permit the purchase of actuarially sound coverage for the costs of end stage renal disease.

(7)(A) The Secretary shall establish protocols on standards and conditions for the reuse of dialyzer filters for those facilities and providers which voluntarily elect to reuse such filters.[1112]

[1112] See Vol. II, P.L. 99-509, §9335(k)(2) [as amended by P.L. 100-203], with respect to the protocols deadline.

(B) With respect to dialysis services furnished on or after January 1, 1988 (or July 1, 1988, with respect to protocols that relate to the reuse of bloodlines), no dialysis facility may reuse dialysis supplies (other than dialyzer filters) unless the Secretary has established a protocol with respect to the reuse of such supplies and the facility follows the protocol so established.

(C) The Secretary shall incorporate protocols established under this paragraph, and the requirement of subparagraph (B), into the requirements for facilities prescribed under subsection (b)(1)(A) and failure to follow such a protocol or requirement subjects such a facility to denial of participation in the program established under this section and to denial of payment for dialysis treatment not furnished in compliance with such a protocol or in violation of such requirement.

(8) The Secretary shall submit to the Congress no later than October 1, 1979, a full report on the experiments conducted under paragraphs (1), (2), (3), and (7), and the studies under paragraphs (4), (5), (6), and (7). Such report shall include any recommendations for legislative changes which the Secretary finds necessary or desirable as a result of such experiments and studies.

(g)(1) In any case where the Secretary—

(A) finds that a renal dialysis facility is not in substantial compliance with requirements for such facilities prescribed under subsection (b)(1)(A),

(B) finds that the facility's deficiencies do not immediately jeopardize the health and safety of patients, and

(C) has given the facility a reasonable opportunity to correct its deficiencies,

the Secretary may, in lieu of terminating approval of the facility, determine that payment under this title shall be made to the facility only for services furnished to individuals who were patients of the facility before the effective date of the notice.

(2) The Secretary's decision to restrict payments under this subsection shall be made effective only after such notice to the public and to the facility as may be prescribed in regulations, and shall remain in effect until (A) the Secretary finds that the facility is in substantial compliance with the requirements under subsection (b)(1)(A), or (B) the Secretary terminates the agreement under this title with the facility.

(3) A facility dissatisfied with a determination by the Secretary under paragraph (1) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

[1113] CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES[1114]

SEC. 1882. [42 U.S.C. 1395ss] (a)(1)[1115] The Secretary shall establish a procedure whereby medicare supplemental policies (as defined in subsection (g)(1)) may be certified by the Secretary as meeting minimum standards and requirements set forth in subsection (c). Such procedure shall provide an opportunity for any insurer to submit any such policy, and such additional data as the Secretary finds necessary, to the Secretary for his examination and for his certification thereof as meeting the standards and requirements set forth in subsection (c). Subject to subsections (k)(3),[1116] (m), and (n)[1117], such certification shall remain in effect if the insurer files a notarized statement with the Secretary no later than June 30 of each year stating that the policy continues to meet such standards and requirements and if the insurer submits such additional data as the Secretary finds necessary to independently verify the accuracy of such notarized statement. Where the Secretary determines such a policy meets (or continues to meet) such standards and requirements, he shall authorize the insurer to have printed on such policy (but only in accordance with such requirements and conditions as the Secretary may prescribe) an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification. The Secretary shall provide each State commissioner or superintendent of insurance with a list of all the policies which have received his certification.

[1113] P.L. 101-508, §4353(a)(1), struck out "VOLUNTARY", effective November 5, 1990.

[1114] The abbreviation "NAIC" as used in this section means National Association of Insurance Commissioners; see §1882(g)(2)(A).

See Vol. II, P.L. 101-508, §4358(d), with respect to the Secretary's report to Congress.

[1115] P.L. 101-508, §4353(a)(2)(A), redesignated subsection (a) as paragraph (1), effective November 5, 1990.

(2) No medicare supplemental policy may be issued in a State on or after the date specified in subsection (p)(1)(C) unless—

(A) the State's regulatory program under subsection (b)(1) provides for the application and enforcement of the standards and requirements set forth in such subsection (including the NAIC standards or the Federal standards (as the case may be)) by the date specified in subsection (p)(1)(C); or

(B) if the State's program does not provide for the application and enforcement of such standards and requirements, the policy has been certified by the Secretary under paragraph (1) as meeting the standards and requirements set forth in subsection (c) (including such applicable standards) by such date.

Any person who issues a medicare supplemental policy, after the effective date of the NAIC or Federal standards with respect to the policy, in violation of this paragraph is subject to a civil money penalty of not to exceed $25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).[1118]

(b)(1) Any medicare supplemental policy issued in any State which the the[1119] Secretary[1120] determines has established under State law a regulatory program that—

(A) provides for the application and enforcement[1121] of standards with respect to such policies equal to or more stringent than the NAIC Model Standards (as defined in subsection (g)(2)(A)), except as otherwise provided by subparagraph (H)[1122];

[1116] P.L. 101-508, §4027(sic)(k)(1), struck out "(k)(4),", effective November 5, 1990.

[1117] P.L. 101-234, §203(a)(1)(A), struck out "subsection (k)(3)" and substituted "subsections (k)(3), (k)(4), (m), and (n)", effective January 1, 1990.

[1118] P.L. 101-508, §4353(a)(2)(B), added paragraph (2), effective November 5, 1990.

[1119] As in original.

[1120] P.L. 101-508, §4353(b)(1), struck out "Supplemental Health Insurance Panel (established under paragraph (2))" and substituted "the Secretary", effective November 5, 1990.

[1121] P.L. 101-508, §4353(b)(3), inserted "and enforcement", effective November 5, 1990.

(B) includes requirements equal to or more stringent than the requirements described in paragraphs (2) through (5)[1123] of subsection (c);

(C) provides that—

(i) information with respect to the actual ratio of benefits provided to premiums collected under such policies will be reported to the State on forms conforming to those developed by the National Association of Insurance Commissioners for such purpose, or

(ii) such ratios will be monitored under the program in an alternative manner approved by the Secretary, and that a copy of each such policy, the most recent premium for each such policy, and a listing of the ratio of benefits provided to premiums collected for the most recent 3-year period for each such policy issued or sold in the State is maintained and made available to interested persons;[1124]

(D) provides for application and enforcement[1125] of the standards and requirements described in subparagraphs (A), (B), and (C) to all medicare supplemental policies (as defined in subsection (g)(1)) issued in such State,[1126]

(E) provides the Secretary periodically (but at least annually) with a list containing the name and address of the issuer of each such policy and the name and number of each such policy (including an indication of policies that have been previously approved, newly approved, or withdrawn from approval since the previous list was provided),[1127]

(F) reports to the Secretary on the implementation and enforcement of standards and requirements of this paragraph at intervals established by the Secretary,[1128]

(G) provides for a process for approving or disapproving proposed premium increases with respect to such policies, and establishes a policy for the holding of public hearings prior to approval of a premium increase,[1129] and[1130]

(H) in the case of a policy that meets the standards under subparagraph (A) except that benefits under the policy are limited to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), provides for the application of requirements equal to or more stringent than the requirements under subsection (t),[1131]

[1122] P.L. 101-508, §4358(b)(2)(A), inserted ", except as otherwise provided by subparagraph (H)", only applicable in 15 States (as determined by the Secretary of Health and Human Services) and only during the 3-year period beginning with 1992.

[1123] P.L. 101-508, §4351(a)(1), struck out "(4)" and substituted "(5)", effective November 5, 1990.

[1124] P.L. 101-508, §4355(b), struck out a semicolon and substituted ", and that a copy of each such policy, the most recent premium for each such policy, and a listing of the ratio of benefits provided to premiums collected for the most recent 3-year period for each such policy issued or sold in the State is maintained and made available to interested persons;", applicable to policies sold or issued more than 1 year after November 5, 1990.

[1125] P.L. 101-508, §4353(b)(3), inserted "and enforcement", effective November 5, 1990.

[1126] P.L. 101-508, §4353(c)(1), struck out "and", effective November 5, 1990.

[1127] P.L. 101-508, §4353(c)(2), inserted "and".
P.L. 101-508, §4355(c)(1), struck out "and".

[1128] P.L. 101-508, §4353(c)(3), added subparagraph (F), effective November 5, 1990.
P.L. 101-508, §4355(c)(2), added "and".
P.L. 101-508, §4358 (b)(2)(B), struck out "and".

[1129] P.L. 101-508, §4355(c)(3), added subparagraph (G), applicable to policies sold or issued more than 1 year afer November 5, 1990.

[1130] P.L. 101-508, §4358(b)(2)(C), added "and".

shall be deemed (subject to subsections (k)(3),[1132] (m), and (n)[1133], for so long as the Secretary[1134] finds that such State regulatory program continues to meet the standards and requirements of this paragraph) to meet the standards and requirements set forth in subsection (c). The report required under subsection (F)[1135] shall include information on loss ratios of policies sold in the State, frequency and types of instances in which policies approved by the State fail to meet the standards of this paragraph, actions taken by the State to bring such policies into compliance, and information regarding State programs implementing consumer protection provisions, and such further information as the Secretary in consultation with the National Association of Insurance Commissioners, may specify.[1136]

(2) The Secretary periodically shall review State regulatory programs to determine if they continue to meet the standards and requirements specified in paragraph (1). If the Secretary finds that a State regulatory program no longer meets the standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the State regulatory program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the program shall no longer be considered to have in operation a program meeting such standards and requirements.[1137]

(3) Notwithstanding paragraph (1), a medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c), with respect to an advertisement (whether through written, radio, or television medium) used (or, at a State's option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State for review or approval to the extent it may be required under State law.[1138]

(c) The Secretary shall certify under this section any medicare supplemental policy, or continue certification of such a policy, only if he finds that such policy (or, with respect to paragraph (3) or the requirement described in subsection (s)[1139], the issuer of the policy)—

[1131] P.L. 101-508, §4358(b)(2)(D), added subparagraph (H), only applicable in 15 States (as determined by the Secretary) and only during the 3-year period beginning with 1992.

[1132] P.L. 101-508, §4027(sic)(k)(1), struck out "(k)(4),", effective November 5, 1990.

[1133] P.L. 101-234, §203(a)(1)(A), struck out "subsection (k)(3)" and substituted "subsections (k)(3), (k)(4), (m), and (n)", effective January 1, 1990.

[1134] P.L. 101-508, §4353(b)(2), struck out "the Panel" and substituted "the Secretary", effective November 5, 1990.

[1135] Probably should be "subparagraph (F)".

[1136] P.L. 101-508, §4353(c)(5)(sic), added this sentence, effective November 5, 1990.

[1137] P.L. 101-508, §4353(b)(4), amended paragraph (2) in its entirety, effective November 5, 1990. [For paragraph (2) as it formerly read, see Vol. III, P.L. 101-508.]

[1138] P.L. 100-360, §221(e), added paragraph (3), applicable to medicare supplemental policies as of January 1, 1989, with respect to advertising used on or after such date*.

*P.L. 101-234, §203(d), struck out "effective July 1, 1988" and substituted "applicable to medicare supplemental policies as of January 1, 1989, with respect to advertising used on or after such date".

[1139] P.L. 101-508, §4357(a)(1), inserted "or the requirement described in subsection (s)", effective 1 year after November 5, 1990.

(1) meets or exceeds (either in a single policy or, in the case of nonprofit hospital and medical service associations, in one or more policies issued in conjunction with one another) the NAIC Model Standards (except as otherwise provided by subsection (t))[1140];

(2) meets the requirements of subsection (r);[1141]

(3)(A) accepts a notice under section 1842(h)(3)(B) as a claim form for benefits under such policy in lieu of any claim form otherwise required and agrees to make a payment determination on the basis of the information contained in such notice;

(B) where such a notice is received—

(i) provides notice to such physician or supplier and the beneficiary of the payment determination under the policy, and

(ii) provides any payment covered by such policy directly to the participating physician or supplier involved;

(C) provides each enrollee at the time of enrollment a card listing the policy name and number and a single mailing address to which notices under section 1842(h)(3)(B) respecting the policy are to be sent;

(D) agrees to pay any user fees established under section 1842(h)(3)(B) with respect to information transmitted to the issuer of the policy; and

(E) provides to the Secretary at least annually, for transmittal to carriers, a single mailing address to which notices under section 1842(h)(3)(B) respecting the policy are to be sent;[1142]

(4) may, during a period of not less than 30 days after the policy is issued, be returned for a full refund of any premiums paid (without regard to the manner in which the purchase of the policy was solicited); and[1143]

(5) meets the applicable requirements of subsections (o) through (t).[1144] [1145]

(d)(1) Whoever knowingly and willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the compliance of any policy with the standards and requirements set forth in subsection (c) or in regulations promulgated pursuant to such subsection, or with respect to the use of the emblem designed by the Secretary under subsection (a), shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

[1140] P.L. 101-508, §4358(b)(1), inserted "(except as otherwise provided by subsection (t))", only applicable in 15 States (as determined by the Secretary) and only during the 3-year period beginning with 1992.

[1141] P.L. 101-508, §4355(a)(1), amended paragraph (2) in its entirety, applicable to policies sold or issued more than 1 year after November 5, 1990. Until then, paragraph (2) continues to read as follows:

"(2) can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such period and in accordance with accepted actuarial principles and practices) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 60 percent of the aggregate amount of premiums collected in the case of individual policies;".

[1142] P.L. 101-508, §4351(a)(2)(A), struck out "and".

[1143] P.L. 101-508, §4351(a)(2)(B), struck out a period and substituted "; and".

[1144] P.L. 101-508, §4351(a)(2)(C), added this paragraph, effective November 5, 1990.

[1145] P.L. 101-508, §4355(a)(2), struck out "For purposes of paragraph (2), policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.", applicable to policies sold or issued more than 1 year after November 5, 1990.

(2) Whoever falsely assumes or pretends to be acting, or misrepresents in any way that he is acting, under the authority of or in association with, the program of health insurance established by this title, or any Federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value, shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

(3)(A) It is unlawful for a person to sell or issue[1146] a health insurance policy to an individual entitled to benefits under part A or enrolled under part B of this title, with knowledge that such policy[1147] duplicates health benefits to which such individual is otherwise entitled, other than benefits to which he is entitled under a requirement of State or Federal law (other than this title or title XIX[1148]). Whoever violates the previous sentence shall be fined[1149] under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a person other than the issuer of the policy)[1150] for each such prohibited act. A seller (who is not the issuer of a health insurance policy) shall not be considered to violate the previous sentence if the policy is sold in compliance with subparagraph (B) and the statement under such subparagraph indicates on its face that the sale of the policy will not duplicate health benefits to which the individual is otherwise entitled.[1151] This subsection shall not apply to such a seller until such date as the Secretary publishes a list of the standardized benefit packages that may be offered consistent with subsection (p).[1152]

(B)(i) It is unlawful for a person to issue or sell a medicare supplemental policy to an individual entitled to benefits under part A or enrolled under part B, whether directly, through the mail, or otherwise, unless—

(I) the person obtains from the individual, as part of the application for the issuance or purchase and on a form described in clause (II), a written statement signed by the individual stating, to the best of the individual's knowledge, what health insurance policies the individual has, from what source, and whether the individual is entitled to any medical assistance under title XIX, whether as a qualified medicare beneficiary or otherwise, and

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[1146] P.L. 101-508, §4354(a)(1)(A), struck out "Whoever knowingly sells" and substituted "It is unlawful for a person to sell or issue", applicable to policies issued or sold more than 1 year after November 5, 1990.

[1147] P.L. 101-508, §4354(a)(1)(B), struck out "substantially", applicable to policies issued or sold more than 1 year after November 5, 1990.

[1148] P.L. 101-508, §4354(a)(1)(D), inserted "or title XIX", applicable to policies issued or sold more than 1 year after November 5, 1990.

[1149] P.L. 101-508, §4354(a)(1)(C), struck out ", shall be fined" and substituted ". Whoever violates the previous sentence shall be fined", applicable to policies issued or sold more than 1 year after November 5, 1990.

[1150] P.L. 101-508, §4354(a)(1)(E), struck out "$5,000" and substituted "$25,000 (or $15,000 in the case of a person other than the issuer of the policy)", applicable to policies issued or sold more than 1 year after November 5, 1990.

[1151] P.L. 101-508, §4354(a)(1)(F), added this sentence, applicable to policies issued or sold more than 1 year after November 5, 1990.

[1152] P.L. 101-508, §4354(a)(1)(F), added this sentence, applicable to policies issued or sold more than 1 year after November 5, 1990.

(II) the written statement is accompanied by a written acknowledgment, signed by the seller of the policy, of the request for and receipt of such statement.

(ii) The statement required by clause (i) shall be made on a form that—

(I) states in substance that a medicare-eligible individual does not need more than one medicare supplemental policy,

(II) states in substance that individuals 65 years of age or older may be eligible for benefits under the State medicaid program under title XIX and that such individuals who are entitled to benefits under that program usually do not need a medicare supplemental policy and that benefits and premiums under any such policy shall be suspended upon request of the policyholder during the period (of not longer than 24 months) of entitlement to benefits under such title and may be reinstituted upon loss of such entitlement, and

(III) states that counseling services may be available in the State to provide advice concerning the purchase of medicare supplemental policies and enrollment under the medicaid program and may provide the telephone number for such services.

(iii)(I) Except as provided in subclauses (II) and (III), if the statement required by clause (i) is not obtained or indicates that the individual has another medicare supplemental policy or indicates that the individual is entitled to any medical assistance under title XIX, the sale of such a policy shall be considered to be a violation of subparagraph (A).

(II) Subclause (I) shall not apply in the case of an individual who has another policy, if the individual indicates in writing, as part of the application for purchase, that the policy being purchased replaces such other policy and indicates an intent to terminate the policy being replaced when the new policy becomes effective and the issuer or seller certifies in writing that such policy will not, to the best of the issuer[1153] or seller's knowledge, duplicate coverage (taking into account any such replacement).

(III) Subclause (I) also shall not apply if a State medicaid plan under title XIX pays the premiums for the policy, or pays less than an individual's (who is described in section 1905(p)(1)) full liability for medicare cost sharing as defined in section 1905(p)(3)(A).

(iv) Whoever issues or sells a medicare supplemental policy in violation of this subparagraph shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not the issuer of a policy) for each such violation.[1154]

[1153] Probably should be "issuer's".

[1154] P.L. 101-508, §4354(a)(2), amended subparagraph (B) in its entirety, applicable to policies issued or sold more than 1 year after November 5, 1990. Until then, subparagraph (B) reads as follows:

"(B) For purposes of this paragraph, benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual, shall not be considered as duplicative.".

(C) Subparagraph (A) shall not apply with respect to the selling of a group policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations.

(4)(A) Whoever knowingly, directly or through his agent, mails or causes to be mailed any matter for a prohibited purpose (as determined under subparagraph (B)) shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

(B) For purposes of subparagraph (A), a prohibited purpose means the advertising, solicitation, or offer for sale of a medicare supplemental policy, or the delivery of such a policy, in or into any State in which such policy has not been approved by the State commissioner or superintendent of insurance.[1155]

(C) Subparagraph (A) shall not apply in the case of a person who mails or causes to be mailed a medicare supplemental policy into a State if such person has ascertained that the party insured under such policy to whom (or on whose behalf) such policy is mailed is located in such State on a temporary basis.

(D) Subparagraph (A) shall not apply in the case of a person who mails or causes to be mailed a duplicate copy of a medicare supplemental policy previously issued to the party to whom (or on whose behalf) such duplicate copy is mailed, if such policy expires not more than 12 months after the date on which the duplicate copy is mailed.

(5) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under paragraphs (1), (2), (3)(A), and (4)(A) in the same manner as such provisions apply to penalties and proceedings under section 1128A(a).

(e)(1) The Secretary shall provide to all individuals entitled to benefits under this title (and, to the extent feasible, to individuals about to become so entitled) such information as will permit such individuals to evaluate the value of medicare supplemental policies to them and the relationship of any such policies to benefits provided under this title.

(2) The Secretary shall—

(A) inform all individuals entitled to benefits under this title (and, to the extent feasible, individuals about to become so entitled) of—

(i) the actions and practices that are subject to sanctions under subsection (d), and

(ii) the manner in which they may report any such action or practice to an appropriate official of the Department of Health and Human Services (or to an appropriate State official), and

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[1155] P.L. 101-508, §4353(d)(1), struck out "For purposes of this paragraph, a medicare supplemental policy shall be deemed to be approved by the commissioner or superintendent of insurance of a State if—", clauses (i)-(iii), and "except that such a policy shall not be deemed to be approved by a State commissioner or superintendent of insurance if the State notifies the Secretary that such policy has been submitted for approval to the State and has been specifically disapproved by such State after providing appropriate notice and opportunity for hearing pursuant to the procedures (if any) of the State.", applicable to policies mailed, or caused to be mailed, on and after July 1, 1991. [For clauses (i)-(iii) as they formerly read, see Vol. III, P.L. 101-508.]

(B) publish the toll-free telephone number for individuals to report suspected violations of the provisions of such subsection.

(3) The Secretary shall provide individuals entitled to benefits under this title (and, to the extent feasible, individuals about to become so entitled) with a listing of the addresses and telephone numbers of State and Federal agencies and offices that provide information and assistance to individuals with respect to the selection of medicare supplemental policies.

(f)(1)(A) The Secretary shall, in consultation with Federal and State regulatory agencies, the National Association of Insurance Commissioners, private insurers, and organizations representing consumers and the aged, conduct a comprehensive study and evaluation of the comparative effectiveness of various State approaches to the regulation of medicare supplemental policies in (i) limiting marketing and agent abuse, (ii) assuring the dissemination of such information to individuals entitled to benefits under this title (and to other consumers) as is necessary to permit informed choice, (iii) promoting policies which provide reasonable economic benefits for such individuals, (iv) reducing the purchase of unnecessary duplicative coverage, (v) improving price competition, and (vi) establishing effective approved State regulatory programs described in subsection (b).

(B) Such study shall also address the need for standards or certification of health insurance policies, other than medicare supplemental policies, sold to individuals eligible for benefits under this title.

(C) The Secretary shall, no later than January 1, 1982, submit a report to the Congress on the results of such study and evaluation, accompanied by such recommendations as the Secretary finds warranted by such results with respect to the need for legislative or administrative changes to accomplish the objectives set forth in subparagraphs (A) and (B), including the need for a mandatory Federal regulatory program to assure the marketing of appropriate types of medicare supplemental policies, and such other means as he finds may be appropriate to enhance effective State regulation of such policies.

(2) The Secretary shall submit to the Congress no later than July 1, 1982, and periodically as may be appropriate thereafter (but not less often than once every 2 years), a report evaluating the effectiveness of the certification procedure and the criminal penalties established under this section, and shall include in such reports an analysis of—

(A) the impact of such procedure and penalties on the types, market share, value, and cost to individuals entitled to benefits under this title of medicare supplemental policies which have been certified by the Secretary;

(B) the need for any change in the certification procedure to improve its administration or effectiveness; and

(C) whether the certification program and criminal penalties should be continued.

(g)(1) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations and does not include a policy or plan of a health maintenance organization or other direct service organization which offers benefits under this title, including such services under a contract under under[1156] section 1876 or an agreement under section 1833[1157]. For purposes of this section, the term "policy" includes a certificate issued under such policy.

(2) For purposes of this section:

(A) The term "NAIC Model Standards" means the "NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act", adopted by the National Association of Insurance Commissioners on June 6, 1979, as it applies to medicare supplement[1158] policies.

(B) The term "State with an approved regulatory program" means a State for which the Panel has made a determination under subsection (b)(1).

(C) The State in which a policy is issued means—

(i) in the case of an individual policy, the State in which the policyholder resides; and

(ii) in the case of a group policy, the State in which the holder of the master policy resides.

(h) The Secretary shall prescribe such regulations as may be necessary for the effective, efficient, and equitable administration of the certification procedure established under this section. The Secretary shall first issue final regulations to implement the certification procedure established under subsection (a) not later than March 1, 1981.

(i)(1) No medicare supplemental policy shall be certified and no such policy may be issued bearing the emblem authorized by the Secretary under subsection (a) until July 1, 1982. On and after such date policies certified by the Secretary may bear such emblem, including policies which were issued prior to such date and were subsequently certified, and insurers may notify holders of such certified policies issued prior to such date using such emblem in the notification.

(2)(A) The Secretary shall not implement the certification program established under subsection (a) with respect to policies issued in a State unless the Panel makes a finding that such State cannot be expected to have established, by July 1, 1982, an approved State regulatory program meeting the standards and requirements of subsection (b)(1). If the Panel makes such a finding, the Secretary shall implement such program under subsection (a) with respect to medicare supplemental policies issued in such State, until such time as the Panel determines that such State has a program that meets the standards and requirements of subsection (b)(1).

[1156] As in original.

[1157] P.L. 101-508, §4356(a), inserted "and does not include a policy or plan of a health maintenance organization or other direct service organization which offers benefits under this title, including such services under a contract under under section 1876 or an agreement under section 1833", effective November 5, 1990.

[1158] As in original. Probably should be "supplemental".

(B) Any finding by the Panel under subparagraph (A) shall be transmitted in writing, not later than January 1, 1982, to the Committee on Finance of the Senate and to the Committee on Interstate and Foreign Commerce and the Committee on Ways and Means of the House of Representatives and shall not become effective until 60 days after the date of its transmittal to the Committees of the Congress under this subparagraph. In counting such days, days on which either House is not in session because of an adjournment sine die or an adjournment of more than three days to a day certain are excluded in the computation.

(j) Nothing in this section shall be construed so as to affect the right of any State to regulate medicare supplemental policies which, under the provisions of this section, are considered to be issued in another State.

(k)(1)(A) If, within the 90-day period beginning on the date of the enactment of this subsection[1159], the National Association of Insurance Commissioners (in this subsection referred to as the "Association") amends the NAIC Model Regulation adopted on June 6, 1979 (as it relates to medicare supplemental policies), with respect to matters such as minimum benefit standards, loss ratios, disclosure requirements, and replacement requirements and provisions otherwise necessary to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988[1160], except as provided in subsection (m),[1161] subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the Model Regulation as amended by the Association in accordance with this paragraph (in this subsection and subsection (l) referred to as the "amended NAIC Model Regulation").

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the amended NAIC Model Regulation or 1 year after the date the Association first adopts such amended Regulation.

(2)(A) If the Association does not amend the NAIC Model Regulation within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, Federal model standards (in this subsection and subsection (l) referred to as "Federal model standards") for medicare supplemental policies to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, and subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to Federal model standards.

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the Federal model standards or 1 year after the date the Secretary first promulgates such standards.

[1159] July 1, 1988.

[1160] P.L. 100-360.

[1161] P.L. 101-234, §203(a)(1)(B)(i), inserted "except as provided in subsection (m),", effective January 1, 1990.

(3) Notwithstanding any other provision of this section (except as provided in subsections (l), (m), and (n)[1162])—

(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

(B) no certification made pursuant to subsection (a) shall remain in effect, and

(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the amended NAIC Model Regulation or the Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

(l)(1) Until the date specified in paragraph (3), in the case of a qualifying medicare supplemental policy described in paragraph (2) issued—

(A) before January 1, 1989, the policy is deemed to remain in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation (including giving notices to subscribers and filing for premium adjustments with the State as described in section 5.B. of such Regulation) by January 1, 1989; or

(B) on or after January 1, 1989, the policy is deemed to be in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation before the date of the sale of the policy.

(2) In paragraph (1), the term "qualifying medicare supplemental policy" means a medicare supplemental policy—

(A) issued in a State which—

(i) has not adopted standards equal to or more stringent than the NAIC Model Transition Regulation by January 1, 1989, and

(ii) has not adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards) by January 1, 1989; and

(B) which has been issued in compliance with this section (as in effect on June 1, 1988).

(3)(A) The date specified in this paragraph is the earlier of—

(i) the first date a State adopts, after January 1, 1989, standards equal to or more stringent than the NAIC Model Transition Regulation or equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), as the case may be, or

(ii) the later of (I) the date specified in subsection (k)(1)(B) or (k)(2)(B) (as the case may be), or (II) the date specified in subparagraph (B).

(B) In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

(ii) having a legislature which is not scheduled to meet in 1989 in a legislative session in which such legislation may be considered, the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1989, and in which legislation described in clause (i) may be considered. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

[1162] P.L. 101-234, §203(a)(1)(B)(ii), struck out "subsection (l)" and substituted "subsections (l), (m), and (n)", effective January 1, 1990.

(4) In the case of a medicare supplemental policy in effect on January 1, 1989, and offered in a State which, as of such date—

(A) has adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), but

(B) does not have in effect standards equal to or more stringent than the NAIC Model Transition Regulation (or otherwise requiring notice substantially the same as the notice required in section 5.B. of such Regulation),

the policy shall not be deemed to meet the standards in subsection (c) unless each individual who is entitled to benefits under this title and is a policyholder under such policy on January 1, 1989, is sent such a notice in any appropriate form by not later than January 31, 1989, that explains—

(A) the improved benefits under this title contained in the Medicare Catastrophic Coverage Act of 1988, and

(B) how these improvements affect the benefits contained in the policies and the premium for the policy.

(5) In this subsection, the term "NAIC Model Transition Regulation" refers to the standards contained in the "Model Regulation to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions" (as adopted by the National Association of Insurance Commissioners in September 1987).

(6) The Secretary shall report to the Congress in March 1989 and in July 1990 on actions States have taken in adopting standards equal to or more stringent than the NAIC Model Transition Regulation or the amended NAIC Model Regulation (or Federal model standards).

(m)(1)(A) If, within the 90-day period beginning on the date of the enactment of this subsection, the National Association of Insurance Commissioners (in this subsection and subsection (n) referred to as the "Association") revises the amended NAIC Model Regulation (referred to in subsection (k)(1)(A) and adopted on September 20, 1988) to improve such regulation and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989[1163], subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the amended NAIC Model Regulation (referred to in subsection (k)(1)(A)) as revised by the Association in accordance with this paragraph (in this subsection and subsection (n) referred to as the "revised NAIC Model Regulation").

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised NAIC Model Regulation or 1 year after the date the Association first adopts such revised Regulation.

[1163] P.L. 101-234.

(2)(A) If the Association does not revise the amended NAIC Model Regulation, within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, revised Federal model standards (in this subsection and subsection (n) referred to as "revised Federal model standards") for medicare supplemental policies to improve such standards and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised Federal model standards.

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised Federal model standards or 1 year after the date the Secretary first promulgates such standards.

(3) Notwithstanding any other provision of this section (except as provided in subsection (n))—

(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

(B) no certification made pursuant to subsection (a) shall remain in effect, and

(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).[1164]

(n)(1) Until the date specified in paragraph (4), in the case of a qualifying medicare supplemental policy described in paragraph (3) issued in a State—

(A) before the transition deadline, the policy is deemed to remain in compliance with the standards described in subsection (b)(1)(A) only if the insurer issuing the policy complies with the transition provision described in paragraph (2), or

(B) on or after the transition deadline, the policy is deemed to be in compliance with the standards described in subsection (b)(1)(A) only if the insurer issuing the policy complies with the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) before the date of the sale of the policy.

In this paragraph, the term "transition deadline" means 1 year after the date the Association adopts the revised NAIC Model Regulation or 1 year after the date the Secretary promulgates revised Federal model standards (as the case may be).

(2) The transition provision described in this paragraph is—

(A) such transition provision as the Association provides, by not later than December 15, 1989, so as to provide for an appropriate transition (i) to restore benefit provisions which are no longer duplicative as a result of the changes in benefits under this title made by the Medicare Catastrophic Coverage Repeal Act of 1989 and (ii) to eliminate the requirement of payment for the first 8 days of coinsurance for extended care services, or

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[1164] P.L. 101-234, §203(a)(1)(C), added subsection (m), effective January 1, 1990.

(B) if the Association does not provide for a transition provision by the date described in subparagraph (A), such transition provision as the Secretary shall provide, by January 1, 1990, so as to provide for an appropriate transition described in subparagraph (A).

(3) In paragraph (1), the term "qualifying medicare supplemental policy" means a medicare supplemental policy which has been issued in compliance with this section as in effect on the date before the date of the enactment of this subsection.

(4)(A) The date specified in this paragraph for a policy issued in a State is—

(i) the first date a State adopts, after the date of the enactment of this subsection, standards equal to or more stringent than the revised NAIC Model Regulation (or revised Federal model standards), as the case may be, or

(ii) the date specified in subparagraph (B),

whichever is earlier.

(B) In the case of a State which the Secretary identifies, in consultation with the Association, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

(ii) having a legislature which is not scheduled to meet in 1990 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1990. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(5) In the case of a medicare supplemental policy in effect on January 1, 1990, the policy shall not be deemed to meet the standards in subsection (c) unless each individual who is entitled to benefits under this title and is a policyholder or certificate holder under such policy on such date is sent a notice in an appropriate form by not later than January 31, 1990, that explains—

(A) the changes in benefits under this title effected by the Medicare Catastrophic Coverage Repeal Act of 1989, and

(B) how these changes may affect the benefits contained in such policy and the premium for the policy.

(6)(A) Except as provided in subparagraph (B), in the case of an individual who had in effect, as of December 31, 1988, a medicare supplemental policy with an insurer (as a policyholder or, in the case of a group policy, as a certificate holder) and the individual terminated coverage under such policy before the date of the enactment of this subsection[1165], no medicare supplemental policy of the insurer shall be deemed to meet the standards in subsection (c) unless the insurer—

[1165] Enacted December 13, 1989.

(i) provides written notice, no earlier than December 15, 1989, and no later than January 30, 1990, to the policyholder or certificate holder (at the most recent available address) of the offer described in clause (ii), and

(ii) offers the individual, during a period of at least 60 days beginning not later than February 1, 1990, reinstitution of coverage (with coverage effective as of January 1, 1990), under the terms which (I) do not provide for any waiting period with respect to treatment of pre-existing conditions, (II) provides for coverage which is substantially equivalent to coverage in effect before the date of such termination, and (III) provides for classification of premiums on which terms are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage never terminated.

(B) An insurer is not required to make the offer under subparagraph (A)(ii) in the case of an individual who is a policyholder or certificate holder in another medicare supplemental policy as of the date of the enactment of this subsection, if (as of January 1, 1990) the individual is not subject to a waiting period with respect to treatment of a pre-existing condition under such other policy.[1166]

(o) The requirements of this subsection are as follows:

(1) Each medicare supplemental policy shall provide for coverage of a group of benefits consistent with subsection (p).

(2) If the medicare supplemental policy provides for coverage of a group of benefits other than the core group of basic benefits described in subsection (p)(2)(B), the issuer of the policy must make available to the individual a medicare supplemental policy with only such core group of basic benefits.

(3) The issuer of the policy has provided, before the sale of the policy, an outline of coverage that uses uniform language and format (including layout and print size) that facilitates comparison among medicare supplemental policies and comparison with medicare benefits.[1167]

(p)(1)(A) If, within 9 months after the date of the enactment of this subsection, the National Association of Insurance Commissioners (in this subsection referred to as the "Association") promulgates—

(i) limitations on the groups or packages of benefits that may be offered under a medicare supplemental policy consistent with paragraphs (2) and (3) of this subsection,

(ii) uniform language and definitions to be used with respect to such benefits,

(iii) uniform format to be used in the policy with respect to such benefits, and

(iv) other standards to meet the additional requirements imposed by the amendments made by the Omnibus Budget Reconciliation Act of 1990,

(such limitations, language, definitions, format, and standards referred to collectively in this subsection as "NAIC standards"), subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, included a reference to the NAIC standards.

[1166] P.L. 101-234, §203(a)(1)(C), added subsection (n), effective January 1, 1990.
[1167] P.L. 101-508, §4351(a)(3), added subsection (o), effective November 5, 1990.

(B) If the Association does not promulgate NAIC standards within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, limitations, language, definitions, format, and standards described in clauses (i) through (iv) of such subparagraph (in this subsection referred to collectively as "Federal standards") and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, included a reference to the Federal standards.

(C)(i) Subject to clause (ii), the date specified in this subparagraph for a State is the date the State adopts the NAIC standards or the Federal standards or 1 year after the date the Association or the Secretary first adopts such standards, whichever is earlier.

(ii) In the case of a State which the Secretary identifies, in consultation with the Association, as—

(I) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the NAIC or Federal standards, but

(II) having a legislature which is not scheduled to meet in 1992 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1992. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(D) In promulgating standards under this paragraph, the Association or Secretary shall consult with a working group composed of representatives of issuers of medicare supplemental policies, consumer groups, medicare beneficiaries, and other qualified individuals. Such representatives shall be selected in a manner so as to assure balanced representation among the interested groups.

(E) If benefits (including deductibles and coinsurance) under this title are changed and the Secretary determines, in consultation with the Association, that changes in the NAIC or Federal standards are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

(2) The benefits under the NAIC or Federal standards shall provide—

(A) for such groups or packages of benefits as may be appropriate taking into account the considerations specified in paragraph (3) and the requirements of the succeeding subparagraphs;

(B) for identification of a core group of basic benefits common to all policies,[1168] and

(C) that, subject to paragraph (5)(B), the total number of different benefit packages (counting the core group of basic benefits described in subparagraph (B) and each other combination of benefits that may be offered as a separate benefit package) that may be established in all the States and by all issuers shall not exceed 10.

[1168] Probably should be a semi-colon.

(3) The benefits under paragraph (2) shall, to the extent possible—

(A) provide for benefits that offer consumers the ability to purchase the benefits that are available in the market as of the date of the enactment of this subsection; and

(B) balance the objectives of (i) simplifying the market to facilitate comparisons among policies, (ii) avoiding adverse selection, (iii) providing consumer choice, (iv) providing market stability, and (v) promoting competition.

(4)(A)(i) Except as provided in subparagraph (B), no State with a regulatory program approved under subsection (b)(1) may provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy unless such grouping meets the applicable standards.

(ii) Except as provided in subparagraph (B), the Secretary may not provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy seeking approval by the Secretary unless such grouping meets the applicable standards.

(B) With the approval of the State (in the case of a policy issued in a State with an approved regulatory program) or the Secretary (in the case of any other policy), the issuer of a medicare supplemental policy may offer new or innovative benefits in addition to the benefits provided in a policy that otherwise complies with the applicable standards. Any such new or innovative benefits may include benefits that are not otherwise available and are cost-effective and shall be offered in a manner which is consistent with the goal of simplification of medicare supplemental policies.

(5)(A) Except as provided in subparagraph (B), this subsection shall not be construed as preventing a State from restricting the groups of benefits that may be offered in medicare supplemental policies in the State.

(B) A State with a regulatory program approved under subsection (b)(1) may not restrict under subparagraph (A) the offering of a medicare supplemental policy consisting only of the core group of benefits described in paragraph (2)(B).

(6) The Secretary may waive the application of standards in regard to the limitation of benefits described in paragraph (4) in those States that on the date of enactment of this subsection had in place an alternative simplification program.

(7) This subsection shall not be construed as preventing an issuer of a medicare supplemental policy who otherwise meets the requirements of this section from providing, through an arrangement with a vendor, for discounts from that vendor to policyholder or certificate-holders for the purchase of items or services not covered under its medicare supplemental policies.

(8) Any person who sells or issues a medicare supplemental policy, after the effective date of the NAIC or Federal standards with respect to the policy, in violation of the previous requirements of this subsection is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not an issuer of a policy) for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall

apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(9)(A) Anyone who sells a medicare supplemental policy to an individual shall make available for sale to the individual a medicare supplemental policy with only the core group of basic benefits (described in paragraph (2)(B)).

(B) Anyone who sells a medicare supplemental policy to an individual shall provide the individual, before the sale of the policy, an outline of coverage which describes the benefits under the policy. Such outline shall be on a standard form approved by the State regulatory program or the Secretary (as the case may be) consistent with the NAIC or Federal standards under this subsection.

(C) Whoever sells a medicare supplemental policy in violation of this paragraph is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not the issuer of the policy) for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(10) No penalty may be imposed under paragraph (8) or (9) in the case of a seller who is not the issuer of a policy until the Secretary has published a list of the groups of benefit packages that may be sold or issued consistent with this subsection.[1169]

(q) The requirements of this subsection are as follows:

(1) Each medicare supplemental policy shall be guaranteed renewable and—

(A) the issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(B) the issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(2) If the medicare supplemental policy is terminated by the group policyholder and is not replaced as provided under paragraph (2)[1170], the issuer shall offer certificateholders an individual medicare supplemental policy which (at the option of the certificateholder)—

(A) provides for continuation of the benefits contained in the group policy, or

(B) provides for such benefits as otherwise meets the requirements of this section.

(3) If an individual is a certificateholder in a group medicare supplemental policy and the individual terminates membership in the group, the issuer shall—

(A) offer the certificateholder the conversion opportunity described in paragraph (2), or

(B) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(4) If a group medicare supplemental policy is replaced by another group medicare supplemental policy purchased by the

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[1169] P.L. 101-508, §4351(a)(3), added subsection (p), effective November 5, 1990.

[1170] Probably should be "paragraph (4)".

same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.[1171]

(5)(A) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder for the period (not to exceed 24 months) in which the policyholder has applied for and is determined to be entitled to medical assistance under title XIX of the Social Security Act, but only if the policyholder notifies the issuer of such policy within 90 days after the date the individual becomes entitled to such assistance. If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy shall be automatically reinstituted (effective as of the date of termination of such entitlement) under terms described in subsection (n)(6)(A)(ii) as of the termination of such entitlement if the policyholder provides notice of loss of such entitlement within 90 days after the date of such loss.

(B) Nothing in this section shall be construed as affecting the authority of a State, under title XIX of the Social Security Act, to purchase a medicare supplemental policy for an individual otherwise entitled to assistance under such title.

(C) Any person who issues a medicare supplemental policy and fails to comply with the requirements of this paragraph is subject to a civil money penalty of not to exceed $25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).[1172]

(r)(1) A medicare supplemental policy may not be issued or sold in any State unless—

(A) the policy can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such periods and in accordance with a uniform methodology, including uniform reporting standards, developed by the National Association of Insurance Commissioners[1173], to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 65 percent in the case of individual policies; and

(B) the issuer of the policy provides for the issuance of a proportional refund, or a credit against future premiums of a proportional amount, based on the premium paid and in accordance with paragraph (2), of the amount of premiums received necessary to assure that the ratio of aggregate benefits provided to the aggregate premiums collected (net of such refunds or credits) complies with the expectation required under subparagraph (A).

[1171] P.L. 101-508, §4352, added subsection (q), effective November 5, 1990.

[1172] P.L. 101-508, §4354(b), added paragraph (5), applicable to policies issued or sold more than 1 year after November 5, 1990.

[1173] Probably should be "Commissioners)".

For purposes of applying subparagraph (A) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

(2)(A) Paragraph (1)(B) shall be applied with respect to each type of policy by policy number. Paragraph (1)(B) shall not apply to a policy with respect to the first 2 years in which it is in effect. The Comptroller General, in consultation with the National Association of Insurance Commissioners, shall submit to Congress a report containing recommendations on adjustments in the percentages under paragraph (1)(A) that may be appropriate in order to apply paragraph (1)(B) to the first 2 years in which policies are effective.

(B) A refund or credit required under paragraph (1)(B) shall be made to each policyholder insured under the applicable policy as of the last day of the year involved.

(C) Such a refund or credit shall include interest from the end of the policy year involved until the date of the refund or credit at a rate as specified by the Secretary for this purpose from time to time which is not less than the average rate of interest for 13-week Treasury notes.

(D) For purposes of this paragraph and paragraph (1)(B), refunds or credits against premiums due shall be made, with respect to a policy year, not later than the third quarter of the succeeding policy year.

(3) The provisions of this subsection do not preempt a State from requiring a higher percentage than that specified in paragraph (1)(A).

(4) The Secretary shall submit in February of each year (beginning with 1993) a report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on loss-ratios under medicare supplemental policies and the use of sanctions, such as a required rebate or credit or the disllowance[1174] of premium increases, for policies that fail to meet the requirements of this subsection (relating to loss-ratios). Such report shall include a list of the policies that failed to comply with such loss-ratio requirements or other requirements of this section.

(5)(A) The Comptroller General shall periodically, not less often than once every 3 years, perform audits with respect to the compliance of medicare supplemental policies with the loss ratio requirements of this subsection and shall report the results of such audits to the State involved and to the Secretary.

(B) The Secretary may independently perform such compliance audits.

(6)(A) A person who issues a policy in violation of the loss ratio requirements of this subsection is subject to a civil money penalty of not to exceed $25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

[1174] Probably should be "disallowance".

(B) Each issuer of a policy subject to the requirements of paragraph (1)(B) shall be liable to policyholders for credits required under such paragraph.[1175]

(s)(1) If a medicare supplemental policy replaces another medicare supplemental policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new medicare supplemental policy for similar benefits to the extent such time was spent under the original policy.

(2)(A) The issuer of a medicare supplemental policy may not deny or condition the issuance or effectiveness of a medicare supplemental policy, or discriminate in the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition for which an application is submitted during the 6 month period beginning with the first month in which the individual (who is 65 years of age or older) first is enrolled for benefits under part B.

(B) Subject to subparagraph (C), subparagraph (A) shall not be construed as preventing the exclusion of benefits under a policy, during its first 6 months, based on a pre-existing condition for which the policyholder received treatment or was otherwise diagnosed during the 6 months before it became effective.

(C) If a medicare supplemental policy or certificate replaces another such policy or certificate which has been in effect for 6 months or longer, the replacing policy may not provide any time period applicable to pre-existing conditions, waiting periods, elimination periods, and probationary periods in the new policy or certificate for similar benefits.

(3) Any issuer of a medicare supplemental policy that fails to meet the requirements of paragraphs (1) and (2) is subject to a civil money penalty of not to exceed $5,000 for each such failure. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).[1176]

(t)(1) If a policy meets the NAIC Model Standards and otherwise complies with the requirements of this section except that benefits under the policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), the policy shall nevertheless be treated as meeting those standards if—

(A) full benefits are provided for items and services furnished through a network of entities which have entered into contracts with the issuer of the policy;

(B) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable given the circumstances to obtain the services through the network;

(C) the network offers sufficient access;

(D) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network;

[1175] P.L. 101-508, §4355(a)(3), added subsection (r), applicable to policies sold or issued more than 1 year after November 5, 1990.

[1176] P.L. 101-508, §4357(a)(2), added subsection (s), effective 1 year after November 5, 1990.

(E)(i) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of (I) the restrictions on payment under the policy for services furnished other than by or through the network, (II) out of area coverage under the policy, (III) the policy's coverage of emergency services and urgently needed care, and (IV) the availability of a policy through the entity that meets the NAIC standards without reference to this subsection and the premium charged for such policy, and

(ii) each enrollee prior to enrollment acknowledges receipt of the explanation provided under clause (i); and

(F) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the NAIC standards and other requirements of this section without reference to this subsection.

(2) If the Secretary determines that an issuer of a policy approved under paragraph (1)—

(A) fails substantially to provide medically necessary items and services to enrollees seeking such items and services through the issuer's network, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual,

(B) imposes premiums on enrollees in excess of the premiums approved by the State,

(C) acts to expel an enrollee for reasons other than nonpayment of premiums, or

(D) does not provide the explanation required under paragraph (1)(E)(i) or does not obtain the acknowledgment required under paragraph (1)(E)(ii),

is subject to a civil money penalty in an amount not to exceed $25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(3) The Secretary may enter into a contract with an entity whose policy has been certified under paragraph (1) or has been approved by a State under subsection (b)(1)(H) to determine whether items and services (furnished to individuals entitled to benefits under this title and under that policy) are not allowable under section 1862(a)(1). Payments to the entity shall be in such amounts as the Secretary may determine, taking into account estimated savings under contracts with carriers and fiscal intermediaries and other factors that the Secretary finds appropriate. Paragraph (1), the first sentence of paragraph (2)(A), paragraph (2)(B), paragraph (3)(C), paragraph (3)(D), and paragraph (3)(E) of section 1842(b) shall apply to the entity.[1177]

HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES[1178]

[1177] P.L. 101-508, §4358(a), added subsection (t), only applicable in 15 States (as determined by the Secretary) and only during the 3-year period beginning with 1992.

[1178] See Vol. II, P.L. 100-203, §4005(b)(3), with respect to the Secretary's report to Congress.

See Vol. II, P.L. 101-508, §4008(j)(2), with respect to the reasonable cost of routine services; and §4008(j)(3), with respect to swing beds certified prior to May 1, 1987.

SEC. 1883. [42 U.S.C. 1395tt] (a)(1) Any hospital (other than a hospital which has in effect a waiver under subparagraph (A) of the last sentence of section 1861(e)) which has an agreement under section 1866 may (subject to subsection (b)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services.

(2)(A) Notwithstanding any other provision of this title, payment to any hospital for services furnished under an agreement entered into under this section shall be based upon the reasonable cost of the services as determined under subparagraph (B).

(B)(i) The reasonable cost of the services consists of the reasonable cost of routine services (determined under clause (ii)) and the reasonable cost of ancillary services (determined under clause (iii)).

(ii) The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement under this section is equal to the product of—

(I) the number of patient-days during the year for which the services were furnished, and

(II) the average reasonable cost per patient-day, such average reasonable cost per patient-day being the average rate per patient-day paid for routine services during the most recent year for which cost reporting data are available with respect to such services (increased in a compounded manner by the applicable increase for payments for routine service costs of skilled nursing facilities under section 1888 for subsequent cost reporting periods and up to and including such calendar year) under this title to freestanding skilled nursing facilities in the region (as defined in section 1886(d)(2)(D)) in which the facility is located.[1179]

(iii) The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(b) The Secretary may not enter into an agreement under this section with any hospital unless—

(1) except as provided under subsection (g), the hospital is located in a rural area and has less than 100 beds, and

(2) the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 1521 of the Public Health Service Act[1180]) for the State in which the hospital is located.

(c) An agreement with a hospital under this section shall, except as otherwise provided under regulations of the Secretary, be of the same duration and subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1866 and shall, where not inconsistent with any provision of this section, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section 1866; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1866, or during which there is in effect for the hospital a waiver under subparagraph (A) of the last sentence of section 1861(e). A hospital with respect to which an agreement under this section has been terminated shall not be eligible to enter into a new agreement until a two-year period has elapsed from the termination date.

[1179] P.L. 101-508, §4008(j)(1), struck out "the previous calendar year under the State plan (of the State in which the hospital is located) under title XIX to skilled nursing facilities located in the State and which meet the requirements specified in section 1902(a)(28), or, in the case of a hospital located in a State which does not have such a State plan, the average rate per patient-day paid for routine services during the previous calendar year under this title to skilled nursing facilities in such State." and substituted "the most recent year for which cost reporting data are available with respect to such services (increased in a compounded manner by the applicable increase for payments for routine service costs of skilled nursing facilities under section 1888 for subsequent cost reporting periods and up to and including such calendar year) under this title to freestanding skilled nursing facilities in the region (as defined in section 1886(d)(2)(D)) in which the facility is located.", applicable to services furnished on or after October 1, 1990.

[1180] P.L. 78-410.

(d)(1) Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as post-hospital[1181] extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than this section), be deemed to have received post-hospital[1182] extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital[1183] extended care services furnished by a skilled nursing facility under an agreement under section 1866.

(2)(A) Any agreement under this section with a hospital with more than 49 beds shall provide that no payment may be made for extended care services which are furnished to an extended care patient after the end of the 5-day period (excluding weekends and holidays) beginning on an availability date for a skilled nursing facility, unless the patient's physician certifies, within such 5-day period, that the transfer of that patient to that facility is not medically appropriate on the availability date. The Secretary shall prescribe regulations to provide for notice by skilled nursing facilities of availability dates to hospitals which have agreements under this section and which are located within the same geographic region (as defined by the Secretary).

(B) In this paragraph:

(i) The term "availability date" means, with respect to an extended care patient at a hospital, any date on which a bed is available for the patient in a skilled nursing facility located within the geographic region in which the hospital is located.

(ii) The term "extended care patient" means an individual being furnished extended care services at a hospital pursuant to an agreement with the Secretary under this section.

(3) In the case of an agreement for a cost reporting period under this section with a hospital that has more than 49 beds, payment may not be made in the period for patient-days of extended care services that exceed 15 percent of the product of the number of days in the period and the average number of licensed beds in the hospital in the period, except that such payment shall continue to be made in the period for those patients who are receiving extended care services at the time the hospital reaches the limit specified in this paragraph.

[1181] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.
[1182] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.
[1183] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.

(e) During a period for which a hospital has in effect an agreement under this section, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital services, the total reimbursement due for routine services from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital's total routine costs before calculations are made to determine title XVIII reimbursement for routine hospital services.

(f) A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1819. Services furnished by such a hospital which would otherwise constitute post-hospital[1184] extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

(g) The Secretary may enter into an agreement under this section on a demonstration basis with any hospital which does not meet the requirement of subsection (b)(1), if the hospital otherwise meets the requirements of this section.

PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED HOSPITAL FACILITIES

Sec. 1884. [42 U.S.C. 1395uu] (a) Any hospital may file an application with the Secretary (in such form and including such data and information as the Secretary may require) for establishment of a transitional allowance under this title with respect to the closing or conversion of an underutilized hospital facility. The Secretary also may establish procedures, consistent with this section, by which a hospital, before undergoing an actual closure or conversion of a hospital facility, can have a determination made as to whether or not it will be eligible for a transitional allowance under this section with respect to such closure or conversion.

(b) If the Secretary finds, after consideration of an application under subsection (a), that—

(1) the hospital's closure or conversion—

(A) is formally initiated after September 30, 1981,

(B) is expected to benefit the program under this title by (i) eliminating excess bed capacity, (ii) discontinuing an underutilized service for which there are adequate alternative sources, or (iii) substituting for the underutilized service some other service which is needed in the area, and

(C) is consistent with the findings of an appropriate health planning agency and with any applicable State program for reduction in the number of hospital beds in the State, and

(2) in the case of a complete closure of a hospital—

(A) the hospital is a private nonprofit hospital or a local governmental hospital, and

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[1184] P.L. 101-234, §101(a)(1), inserted "post-hospital", effective January 1, 1990.

(B) the closure is not for replacement of the hospital,
the Secretary may include as an allowable cost in the hospital's reasonable cost (for the purpose of making payments to the hospital under this title) an amount (in this section referred to as a "transitional allowance"), as provided in subsection (c).

(c)(1) Each transitional allowance established shall be reasonably related to the prior or prospective use of the facility involved under this title and shall recognize—

(A) in the case of a facility conversion or closure (other than a complete closure of a hospital)—

(i) in the case of a private nonprofit or local governmental hospital, that portion of the hospital's costs attributable to capital assets of the facility which have been taken into account in determining reasonable cost for purposes of determining the amount of payment to the hospital under this title, and

(ii) in the case of any hospital, transitional operating cost increases related to the conversion or closure to the extent that such operating costs exceed amounts ordinarily reimbursable under this title; and

(B) in the case of complete closure of a hospital, the outstanding portion of actual debt obligations previously recognized as reasonable for purposes of reimbursement under this title, less any salvage value of the hospital.

(2) A transitional allowance shall be for a period (not to exceed 20 years) specified by the Secretary, except that, in the case of a complete closure described in paragraph (1)(B), the Secretary may provide for a lump-sum allowance where the Secretary determines that such a one-time allowance is more efficient and economical.

(3) A transitional allowance shall take effect on a date established by the Secretary, but not earlier than the date of completion of the closure or conversion concerned.

(4) A transitional allowance shall not be considered in applying the limits to costs recognized as reasonable pursuant to the third sentence of subparagraph (A) and subparagraph (L)(i) of section 1861(v)(1) of this Act, or in determining whether the reasonable cost exceeds the customary charges for a service for purposes of determining the amount to be paid to a provider pursuant to sections 1814(b) and 1833(a)(2) of this Act.

(d) A hospital dissatisfied with a determination of the Secretary on its application under this section may obtain an informal or formal hearing, at the discretion of the Secretary, by filing (in such form and within such time period as the Secretary establishes) a request for such a hearing. The Secretary shall make a final determination on such application within 30 days after the last day of such hearing.

WITHHOLDING OF PAYMENTS FOR CERTAIN MEDICAID PROVIDERS

SEC. 1885. [42 U.S.C. 1395vv] (a) The Secretary may adjust, in accordance with this section, payments under parts A and B to any institution which has in effect an agreement with the Secretary under section 1866, and any person who has accepted payment on the basis of an assignment under section 1842(b)(3)(B)(ii), where such institution or person—

(1) has (or previously had) in effect an agreement with a State agency to furnish medical care and services under a State plan approved under title XIX, and

(2) from which (or from whom) such State agency (A) has been unable to recover overpayments made under the State plan, or (B) has been unable to collect the information necessary to enable it to determine the amount (if any) of the overpayments made to such institution or person under the State plan.

(b) The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall—

(1) assure that the authority under this section is exercised only on behalf of a State agency which demonstrates to the Secretary's satisfaction that it has provided adequate notice of a determination or of a need for information, and an opportunity to appeal such determination or to provide such information,

(2) determine the amount of the payment to which the institution or person would otherwise be entitled under this title which shall be treated as a setoff against overpayments under title XIX, and

(3) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under title XIX and to which the institution or person would otherwise be entitled under this title.

(c) Notwithstanding any other provision of this Act, from the trust funds established under sections 1817 and 1841, as appropriate, the Secretary shall pay to the appropriate State agency amounts recovered under this section to offset the State agency's overpayment under title XIX. Such payments shall be accounted for by the State agency as recoveries of overpayments under the State plan.

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES[1185]

SEC. 1886. [42 U.S.C. 1395ww] (a)(1)(A)(i) The Secretary, in determining the amount of the payments that may be made under this title with respect to operating costs of inpatient hospital services (as defined in paragraph (4)) shall not recognize as reasonable (in the efficient delivery of health services) costs for the provision of such services by a hospital for a cost reporting period to the extent such costs exceed the applicable percentage (as determined under clause

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[1185] See Vol. II, P.L. 98-21, §601(a)(3), with respect to the Congressional intent concerning implementation of a system for including capital-related costs.

See Vol. II, P.L. 99-272, §9114, with respect to information on the impact of prospective payment system payments on hospitals, and §9115, with respect to special rules for the implementation of policies on hospital reimbursement; and §9204(a), with respect to a moratorium on a laboratory payment demonstration.

See Vol. II, P.L. 99-509, §9302(d)(3) with respect to budget-neutral implementation.

See Vol. II, P.L. 100-119, §107, with respect to special rules for the Medicare program.

See Vol. II, P.L. 100-203, §4001, with respect to the extension of reductions under the final sequester order; §4005(a)(2), with respect to Watertown Memorial Hospital; and §4038, with respect to a rural health medical education demonstration project; and §4005(e), with respect to the grant program for rural health care transition [as amended by P.L. 101-239, §6003(g)(1)(B)(i)].

P.L. 101-234, §201(a)(1), repealed P.L. 100-360, §203(c)(2) and (c)(3), regarding potentially abusive ownership or compensation arrangements, effective January 1, 1990.

See Vol. II, P.L. 100-440, §631, with respect to the Missouri Baptist Hospital.

See Vol. II, P.L. 101-239, §6217 [as amended by P.L. 101-508, §4027(sic)(k)(5)], with respect to inner-city triage demonstration project.

See Vol. II, P.L. 101-403, §115(a) and (b)(2), with respect to extension of certain Medicare hospital payment provisions.

(ii)) of the average of such costs for all hospitals in the same grouping as such hospital for comparable time periods.

(ii) For purposes of clause (i), the applicable percentage for hospital cost reporting periods beginning—

(I) on or after October 1, 1982, and before October 1, 1983, is 120 percent;

(II) on or after October 1, 1983, and before October 1, 1984, is 115 percent; and

(III) on or after October 1, 1984, is 110 percent.

(B)(i) For purposes of subparagraph (A) the Secretary shall establish case mix indexes for all short-term hospitals, and shall set limits for each hospital based upon the general mix of types of medical cases with respect to which such hospital provides services for which payment may be made under this title.

(ii) The Secretary shall set such limits for a cost reporting period of a hospital—

(I) by updating available data for a previous period to the immediate preceding cost reporting period by the estimated average rate of change of hospital costs industry-wide, and

(II) by projecting for the cost reporting period by the applicable percentage increase (as defined in subsection (b)(3)(B)).

(C) The limitation established under subparagraph (A) for any hospital shall in no event be lower than the allowable operating costs of inpatient hospital services (as defined in paragraph (4)) recognized under this title for such hospital for such hospital's last cost reporting period prior to the hospital's first cost reporting period for which this section is in effect.

(D) Subparagraph (A) shall not apply to cost reporting periods beginning on or after October 1, 1983.

(2) The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account—

(A) the special needs of sole community hospitals, of new hospitals, of risk based health maintenance organizations, and of hospitals which provide atypical services or essential community services, and to take into account extraordinary circumstances beyond the hospital's control, medical and paramedical education costs, significantly fluctuating population in the service area of the hospital, and unusual labor costs,

(B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this title, and

(C) a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.

(3) The limitation established under paragraph (1)(A) shall not apply with respect to any hospital which—

(A) is located outside of a standard metropolitan statistical area, and

(B)(i) has less than 50 beds, and

(ii) was in operation and had less than 50 beds on the date of the enactment of this section[1186].

(4) For purposes of this section, the term "operating costs of inpatient hospital services" includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services as such costs are determined on an average per admission or per discharge basis (as determined by the Secretary), and includes the costs of all services for which payment may be made under this title that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to the patient during the 3 days immediately preceding the date of the patient's admission if such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary).[1187] Such term does not include costs of approved educational activities,[1188] a return on equity capital,[1189] other capital-related costs (as defined by the Secretary for periods before October 1, 1987), or costs with respect to administering blood clotting factors to individuals with hemophilia[1190]. [1191]

(b)(1) Notwithstanding section 1814(b) but subject to the provisions of section 1813, if the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a hospital (other than a subsection (d) hospital, as defined in subsection (d)(1)(B)) for a cost reporting period subject to this paragraph—

(A) are less than or equal to the target amount (as defined in paragraph (3)) for that hospital for that period, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to the amount of such operating costs, plus—

(i) 50 percent of the amount by which the target amount exceeds the amount of the operating costs, or

(ii) 5 percent of the target amount,

whichever is less; or

(B) are greater than the target amount, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to (i) the target amount, plus (ii) in the case of cost reporting periods beginning on or after October 1, 1991, an additional amount equal to 50 percent of the amount by which the operating costs exceed the target amount (except that such additional amount may not exceed 10 percent of the target amount) after any exceptions or adjustments are made to such target amount for the cost reporting period;[1192]

[1186] September 3, 1982 [P.L. 97-248; 96 Stat. 324].

[1187] P.L. 101-508, §4003(a), struck out a period and substituted ", and includes the costs of all services for which payment may be made under this title that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to the patient during the 3 days immediately preceding the date of the patient's admission if such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary).". For the effective date, see Vol. II, P.L. 101-508, §4003(b).

[1188] P.L. 99-509, §9320(g)(1), struck out ", costs of anesthesia services provided by a certified registered nurse anesthetist,", applicable to services furnished on or after January 1, 1989, except as provided in P.L. 99-509, §9320(k), as amended by P.L. 101-239.

See Vol. II, P.L. 99-509, §9320.

[1189] P.L. 101-239, §6011(a)(1), struck out "or,", applicable to items furnished after June 19, 1990, and before December 19, 1991.

[1190] P.L. 101-239, §6011(a)(2), inserted ", or costs with respect to administering blood clotting factors to individuals with hemophilia", applicable to items furnished after June 19, 1990, and before December 19, 1991.

[1191] See Vol. II, P.L. 98-369, §2312(d), with respect to a study of methods of reimbursement and a report to Congress.

See Vol. II, P.L. 99-509, §9321(c)(4) [as amended by P.L. 100-119, §107(a)(2)(D), and P.L. 100-203, §4009(j)(6)(D)], for the definition of "capital-related costs".

See Vol. II, P.L. 101-508, §4003(c), with respect to regulations.

except that in no case may the amount payable under this title (other than on the basis of a DRG prospective payment rate determined under subsection (d)) with respect to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a).

[(2) Repealed.[1193]]

(3)(A) Except as provided in subparagraphs (C), (D), and (E) for[1194] purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period—

(i) in the case of the first such reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for such hospital for the preceding 12-month cost reporting period, and

(ii) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase under subparagraph (B) for that particular cost reporting period.

(B)(i) For purposes of subsection (d) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—

(I) for fiscal year 1986, 1/2 percent,

(II) for fiscal year 1987, 1.15 percent,

(III) for fiscal year 1988, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,

(IV) for fiscal year 1989, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,[1195]

(V) for fiscal year 1990, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,[1196]

[1192] P.L. 101-508, §4005(a)(1), amended clause (ii) in its entirety, applicable to cost reporting periods beginning on or after October 1, 1991. [For clause (ii) as it reads until then, see Vol. III, P.L. 101-508.]

[1193] P.L. 98-21, §601(b)(4); 97 Stat. 150.

[1194] P.L. 101-239, §6003(e)(1)(B)(i), struck out "For" and substituted "Except as provided in subparagraph (C), for", effective December 19, 1989.

P.L. 101-239, §6003(f)(2)(i), struck out "subparagraph (C)" and substituted "subparagraphs (C) and (D)", effective December 19, 1989.

P.L. 101-239, §6004(b)(1)(A), struck out "and (D)" and substituted ", (D), and (E)", applicable to cost reporting periods beginning on or after April 1, 1989.

[1195] P.L. 101-239, §6003(a)(1)(A), struck out "and".

(VI) for fiscal year 1991, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,[1197]

(VII) for fiscal year 1992, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,[1198]

(VIII) for fiscal year 1993, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 for hospitals located in a rural area,[1199]

(IX) for fiscal year 1994, the market basket percentage increase for hospitals located in a large urban or other urban area, and the market basket percentage increase plus 1.5 percentage points for hospitals located in a rural area,[1200]

(X) for fiscal year 1995, the market basket percentage increase for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area), and[1201]

(XI)[1202] for fiscal year 1996[1203] and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.

[1196] P.L. 101-239, §6003(a)(1)(C), added this subclause (V), applicable to payments for discharges occurring on or after January 1, 1990.

P.L. 101-508, §4002(a)(1)(A), struck out "and".

[1197] P.L. 101-508, §4002(a)(1)(C), added subclause (VI), applicable to payments for discharges occurring on or after January 1, 1991.

P.L. 101-508, §4002(c)(1)(A), struck out "in all areas," and substituted "in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,", applicable to payments for discharges occurring on or after January 1, 1991.

[1198] P.L. 101-508, §4002(a)(1)(C), added subclause (VII), applicable to payments for discharges occurring on or after January 1, 1991.

P.L. 101-508, §4002(c)(1)(B), struck out "in all areas," and substituted "in a large urban area or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,", applicable to payments for discharges occurring on or after January 1, 1991.

[1199] P.L. 101-508, §4002(a)(1)(C), added subclause (VIII), applicable to payments for discharges occurring on or after January 1, 1991.

P.L. 101-508, §4002(c)(1)(C), struck out "in all areas, and" and substituted "in a large urban or other urban area, and the market basket percentage increase minus 0.55 for hospitals located in a rural area," applicable to payments for discharges occurring on or after January 1, 1991.

[1200] P.L. 101-508, §4002(c)(1)(E), added a new subclause (IX), applicable to payments for discharges occurring on or after January 1, 1991.

[1201] P.L. 101-508, §4002(c)(1)(E), added a new subclause (X), applicable to payments for discharges occurring on or after January 1, 1991.

[1202] P.L. 101-239, §6003(a)(1)(B), redesignated the former subclause (V) as subclause (VI).

P.L. 101-508, §4002(a)(1)(B)(ii), redesignated that subclause (VI) as subclause (IX), applicable to payments for discharges occurring on or after January 1, 1991.

P.L. 101-508, §4002(c)(1)(D)(ii), redesignated that subclause (IX) as subclause (XI), applicable to payments for discharges occurring on or after January 1, 1991.

[1203] P.L. 101-239, §6003(a)(1)(B), struck out "1990" and substituted "1991", applicable to payments for discharges occurring on or after January 1, 1990.

P.L. 101-508, §4002(a)(1)(B)(i), struck out "1991" and substituted "1994", applicable to payments for discharges occurring on or after January 1, 1991.

P.L. 101-508, §4002(c)(1)(D)(i), struck out "1994" and substituted "1996", applicable to payments for discharges occurring on or after January 1, 1991.

(ii) For purposes of subparagraphs (A), (C), (D), and (E),[1204] the "applicable percentage increase" for 12-month cost reporting periods beginning during—

(I) fiscal year 1986, is 0.5 percent,

(II) fiscal year 1987, is 1.15 percent,

(III) fiscal year 1988, is the market basket percentage increase minus 2.0 percentage points, and

(IV) subsequent fiscal years is the market basket percentage increase.

(iii) For purposes of this subparagraph, the term "market basket percentage increase" means, with respect to cost reporting periods and discharges occurring in a fiscal year, the percentage, estimated by the Secretary before the beginning of the period or fiscal year, by which the cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for the period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year.[1205]

(C) In the case of a hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii)), the term "target amount" means—

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

(ii) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(ii)[1206] for discharges occurring in the fiscal year in which that later cost reporting period begins.

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.[1207]

[1204] P.L. 101-239, §6004(b)(1)(B), struck out "subparagraph (A)" and substituted "subparagraphs (A) and (E),", applicable with respect to cost reporting periods beginning on or after April 1, 1989.

P.L. 101-508, §4002(c)(2)(A)(i), struck out "(A) and (E),", and substituted "(A), (C), (D), and (E),", applicable to payments for discharges occurring on or after January 1, 1991.

[1205] See Vol. II, P.L. 99-509, §9321(c)(2), with respect to exclusion of capital-related regulations.

See Vol. II, P.L. 101-234, §101(c)(2)(B), with respect to the transition period for target amounts.

P.L. 101-239, §6003(a)(3), provides that for discharges occurring on or after October 1, 1990, the applicable percentage increase (described in this subparagraph) for discharges occurring during fiscal year 1990 is deemed to have been such percentage increase as provided in subclauses (V) and (VI) as amended by P.L. 101-239.

[1206] P.L. 101-508, §4002(c)(2)(A)(ii), struck out "(B)(i)" and substituted "(B)(ii)", applicable to payments for discharges occurring on or after January 1, 1991.

(D) For cost reporting periods ending on or before March 31, 1993, in the case of a hospital that is a medicare-dependent, small rural hospital (as defined in subsection (d)(5)(G)), the term "target amount" means—

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

(ii) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(ii)[1208] for discharges occurring in the fiscal year in which that later cost reporting period begins.

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.[1209]

(E) In the case of a hospital described in clause (v) of subsection (d)(1)(B), the term "target amount" means—

(i) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital—

(I) the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period (in this subparagraph referred to as the "base cost reporting period") preceding the first cost reporting period for which this subsection was in effect with respect to such hospital, increased (in a compounded manner) by—

(II) the sum of the applicable percentage increases applied to such hospital under this paragraph for cost reporting periods after the base cost reporting period and up to and including such first 12-month cost reporting period, or

(ii) with respect to a later cost reporting period, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(ii) for that later cost reporting period.

There shall be substituted for the base cost reporting period described in clause (i) a hospital's cost reporting period (if any) beginning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.[1210]

[1207] P.L. 101-239, §6003(e)(1)(B)(ii), added subparagraph (C), effective December 19, 1989.

[1208] P.L. 101-508, §4002(c)(2)(A)(ii), struck out "(B)(i)" and substituted "(B)(ii)", applicable to payments for discharges occurring on or after January 1, 1991.

[1209] P.L. 101-239, §6003(f)(2)(ii), added subparagraph (D), effective December 19, 1989.

[1210] P.L. 101-239, §6004(b)(1)(C), added subparagraph (E), applicable to cost reporting periods beginning on or after April 1, 1989.

(4)(A) The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and[1211] including those which he deems necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.[1212] The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.[1213]

(B) In determining under subparagraph (A) whether to assign a new base period which is more representative of the reasonable and necessary cost to a hospital of providing inpatient services, the Secretary shall take into consideration—

(i) changes in applicable technologies and medical practices, or differences in the severity of illness among patients, that increase the hospital's costs;

(ii) whether increases in wages and wage-related costs for hospitals located in the geographic area in which the hospital is located exceed the average of the increases in such costs paid by hospitals in the United States; and

(iii) such other factors as the Secretary considers appropriate in determining increases in the hospital's costs of providing inpatient services.[1214]

(C)[1215] Paragraph (1) shall not apply to payment of hospitals which is otherwise determined under paragraph (3) of section 1814(b).

(5) In the case of any hospital having any cost reporting period of other than a 12-month period, the Secretary shall determine the 12-month period which shall be used for purposes of this section.

(6) In the case of any hospital which becomes subject to the taxes under section 3111 of the Internal Revenue Code of 1954[1216], with respect to any or all of its employees, for part or all of a cost reporting period, and was not subject to such taxes with respect to

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[1211] P.L. 101-239, §6015(a), inserted "including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and", effective with cost reporting periods beginning on or after April 1, 1990.

[1212] P.L. 101-239, §6015(b), provides that by not later than June 17, 1990, the Secretary shall publish instructions specifying the application process to be used in providing exceptions and adjustments under this subparagraph.

[1213] P.L. 101-508, §4005(c)(1)(B), added this sentence, effective November 5, 1990.

[1214] P.L. 101-508, §4005(c)(2)(B), added a new subparagraph (B), effective as if included in the enactment of P.L. 101-239.

[1215] P.L. 101-508, §4005(c)(2)(A), redesignated subparagraph (B) as subparagraph (C), effective as if included in the enactment of P.L. 101-239.

[1216] See P.L. 83-591, §3111 (this volume).

any or all of its employees for all or part of the 12-month base cost reporting period referred to in subsection (b)(3)(A)(i), the Secretary shall provide for an adjustment by increasing the base period amount described in such subsection for such hospital by an amount equal to the amount of such taxes which would have been paid or accrued by such hospital for such base period if such hospital had been subject to such taxes for all of such base period with respect to all its employees, minus the amount of any such taxes actually paid or accrued for such base period.[1217]

(c)(1) The Secretary may provide, in his discretion, that payment with respect to services provided by a hospital in a State may be made in accordance with a hospital reimbursement control system in a State, rather than in accordance with the other provisions of this title, if the chief executive officer of the State requests such treatment and if—

(A) the Secretary determines that the system, if approved under this subsection, will apply (i) to substantially all non-Federal acute care hospitals (as defined by the Secretary) in the State and (ii) to the review of at least 75 percent of all revenues or expenses in the State for inpatient hospital services and of revenues or expenses for inpatient hospital services provided under the State's plan approved under title XIX;[1218]

(B) the Secretary has been provided satisfactory assurances as to the equitable treatment under the system of all entities (including Federal and State programs) that pay hospitals for inpatient hospital services, of hospital employees, and of hospital patients;

(C) the Secretary has been provided satisfactory assurances that under the system, over 36-month periods (the first such period beginning with the first month in which this subsection applies to that system in the State), the amount of payments made under this title under such system will not exceed the amount of payments which would otherwise have been made under this title not using such system;

(D) the Secretary determines that the system will not preclude an eligible organization (as defined in section 1876(b)) from negotiating directly with hospitals with respect to the organization's rate of payment for inpatient hospital services; and

(E) the Secretary determines that the system requires hospitals to meet the requirement of section 1866(a)(1)(G) and the system provides for the exclusion of certain costs in accordance with section 1862(a)(14) (except for such waivers thereof as the Secretary provides by regulation).

The Secretary cannot deny the application of a State under this subsection on the ground that the State's hospital reimbursement control system is based on a payment methodology other than on the basis of a diagnosis-related group or on the ground that the amount of payments made under this title under such system must be less than the amount of payments which would otherwise have been made under this title not using such system. If the Secretary determines that the conditions described in subparagraph (C) are based on maintaining payment amounts at no more than a specified percentage increase above the payment amounts in a base period, the State has the option of applying such test (for inpatient hospital services under part A) on an aggregate payment basis or on the basis of the amount of payment per inpatient discharge or admission. If the Secretary determines that the conditions described in subparagraph (C) are based on maintaining aggregate payment amounts below a national average percentage increase in total payments under part A for inpatient hospital services, the Secretary cannot deny the application of a State under this subsection on the ground that the State's rate of increase in such payments for such services must be less than such national average rate of increase.

[1217] See Vol. II, P.L. 100-360, §104(c)(2), with respect to PPS-exempt hospitals.

See Vol. II, P.L. 101-508, §4005(b), with respect to national prospective payment rates for current non-PPS hospitals.

[1218] See Vol. II, P.L. 99-272, §9108, with respect to continuation of Medicare reimbursement waivers for certain hospitals participating in regional hospital reimbursement demonstrations.

(2) In determining under paragraph (1)(C) the amount of payment which would otherwise have been made under this title for a State, the Secretary may provide for appropriate adjustment of such amount to take into account previous reductions effected in the amount of payments made under this title in the State due to the operation of the hospital reimbursement control system in the State if the system has resulted in an aggregate rate of increase in operating costs of inpatient hospital services (as defined in subsection (a)(4)) under this title for hospitals in the State which is less than the aggregate rate of increase in such costs under this title for hospitals in the United States.

(3) The Secretary shall discontinue payments under a system described in paragraph (1) if the Secretary—

(A) determines that the system no longer meets the requirements of subparagraphs (A), (D), and (E) of paragraph (1) and, if applicable, the requirements of paragraph (5), or

(B) has reason to believe that the assurances described in subparagraph (B) or (C) of paragraph (1) (or, if applicable, in paragraph (5)) are not being (or will not be) met.

(4) The Secretary shall approve the request of a State under paragraph (1) with respect to a hospital reimbursement control system if—

(A) the requirements of subparagraphs (A), (B), (C), (D), and (E) of paragraph (1) have been met with respect to the system, and

(B) with respect to that system a waiver of certain requirements of title XVIII of the Social Security Act has been approved on or before (and which is in effect as of) the date of the enactment of the Social Security Amendments of 1983[1219], pursuant to section 402(a) of the Social Security Amendments of 1967[1220] or section 222(a) of the Social Security Amendments of 1972[1221].

With respect to a State system described in this paragraph, the Secretary shall judge the effectiveness of such system on the basis of its rate of increase or inflation in inpatient hospital payments for individuals under this title, as compared to the national rate of increase or inflation for such payments, with the State retaining the option to have the test applied on the basis of the aggregate payments under the State system as compared to aggregate payments which would have been made under the national system since[1222] October 1, 1984, to the most recent date for which annual data are available[1223].

[1219] April 20, 1983 [P.L. 98-21; 97 Stat. 65].
[1220] P.L. 90-248.
[1221] P.L. 92-603.

(5) The Secretary shall approve the request of a State under paragraph (1) with respect to a hospital reimbursement control system if—

(A) the requirements of subparagraphs (A), (B), (C), (D), and (E) of paragraph (1) have been met with respect to the system;

(B) the Secretary determines that the system—

(i) is operated directly by the State or by an entity designated pursuant to State law,

(ii) provides for payment of hospitals covered under the system under a methodology (which sets forth exceptions and adjustments, as well as any method for changes in the methodology) by which rates or amounts to be paid for hospital services during a specified period are established under the system prior to the defined rate period, and

(iii) hospitals covered under the system will make such reports (in lieu of cost and other reports, identified by the Secretary, otherwise required under this title) as the Secretary may require in order to properly monitor assurances provided under this subsection;

(C) the State has provided the Secretary with satisfactory assurances that operation of the system will not result in any change in hospital admission practices which result in—

(i) a significant reduction in the proportion of patients (receiving hospital services covered under the system) who have no third-party coverage and who are unable to pay for hospital services,

(ii) a significant reduction in the proportion of individuals admitted to hospitals for inpatient hospital services for which payment is (or is likely to be) less than the anticipated charges for or costs of such services,

(iii) the refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital, or

(iv) the refusal to provide emergency services to any person who is in need of emergency services if the hospital provides such services;

(D) any change by the State in the system which has the effect of materially reducing payments to hospitals can only take effect upon 60 days notice to the Secretary and to the hospitals the payment to which is likely to be materially affected by the change; and

(E) the State has provided the Secretary with satisfactory assurances that in the development of the system the State has consulted with local governmental officials concerning the impact of the system on public hospitals.

[1222] P.L. 101-508, §4008(f)(1), struck out "rate of increase from" and substituted "payments under the State system as compared to aggregate payments which would have been made under the national system since", effective as if included in the enactment of P.L. 101-239.

[1223] P.L. 101-239, §6022, struck out "payment or payments per inpatient admission or discharge during the three cost reporting periods beginning on or after October 1, 1983, after which such test, at the option of the Secretary, shall no longer apply, and such State systems shall be treated in the same manner as under other waivers" and substituted "rate of increase from October 1, 1984, to the most recent date for which annual data are available", effective December 19, 1989.

The Secretary shall respond to requests of States under this paragraph within 60 days of the date the request is submitted to the Secretary.

(6) If the Secretary determines that the assurances described in paragraph (1)(C) have not been met with respect to any 36-month period, the Secretary may reduce payments under this title to hospitals under the system in an amount equal to the amount by which the payment under this title under such system for such period exceeded the amount of payments which would otherwise have been made under this title not using such system.

(7) In the case of a State which made a request under paragraph (5) before December 31, 1984, for the approval of a State hospital reimbursement control system and which request was approved—

(A) in applying paragraphs (1)(C) and (6), a reference to a "36-month period" is deemed a reference to a "48-month period", and

(B) in order to allow the State the opportunity to provide the assurances described in paragraph (1)(C) for a 48-month period, the Secretary may not discontinue payments under the system, under the authority of paragraph (3)(A) because the Secretary has reason to believe that such assurances are not being (or will not be) met, before July 1, 1986.[1224]

(d)(1)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year—

(i) beginning on or after October 1, 1983, and before October 1, 1984, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the regional adjusted DRG prospective payment rate determined under paragraph (2) for such discharges;

(ii) beginning on or after October 1, 1984, and before October 1, 1987, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the applicable combined adjusted DRG prospective payment rate determined under subparagraph (D) for such discharges; or

(iii) beginning on or after April 1, 1988, and ending on September 30, 1993,[1225],[1226] the sum of (I) 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, and (II) 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph.[1227]

[1224] See Vol. II, P.L. 99-272, §9202(j), with respect to special treatment of States formerly under waiver.

[1225] P.L. 101-508, §4002(e)(1), struck out "beginning on or after October 1, 1987, is equal to the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, or, if the average standardized amount (described in clause (i)(I) or clause (ii)(I) of paragraph (3)(D)) for hospitals within the region of, and in the same large urban or other area* as, the hospital is greater than the average standardized amount (described in the respective clause)

(B) As used in this section, the term "subsection (d) hospital" means a hospital located in one of the fifty States or the District of Columbia other than—

(i) a psychiatric hospital (as defined in section 1861(f)),

(ii) a rehabilitation hospital (as defined by the Secretary),

(iii) a hospital whose inpatients are predominantly individuals under 18 years of age,[1228]

(iv) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days, or[1229]

(v) a hospital that the Secretary has classified, at any time on or before December 31, 1990, (or, in the case of a hospital that, as of the date of the enactment of this clause[1230], is located in a State operating a demonstration project under section 1814(b), on or before December 31, 1991) for purposes of applying exceptions and adjustments to payment amounts under this subsection, as a hospital involved extensively in treatment for or research on cancer;[1231]

and, in accordance with regulations of the Secretary, does not include a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital (as defined by the Secretary).

(C) For purposes of this subsection, for cost reporting periods beginning—

(i) on or after October 1, 1983, and before October 1, 1984, the "target percentage" is 75 percent and the "DRG percentage" is 25 percent;

(ii) on or after October 1, 1984, and before October 1, 1985, the "target percentage" is 50 percent and the "DRG percentage" is 50 percent;

(iii) on or after October 1, 1985, and before October 1, 1986, the "target percentage" is 45 percent and the "DRG percentage" is 55 percent; and

(iv) on or after October 1, 1986, and before October 1, 1987, the "target percentage" is 25 percent and the "DRG percentage" is 75 percent.

(D) For purposes of subparagraph (A)(ii)(II), the "applicable combined adjusted DRG prospective payment rate" for discharges occurring—

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for hospitals within the United States in that type of area for discharges occurring during the period beginning on April 1, 1988, and ending on October 20[**], 1990" and substituted "beginning on or after April 1, 1988, and ending on September 30, 1993,", applicable to discharges occurring on or after October 1, 1990.

[*] P.L. 101-508, §4002(c)(2)(B)(i), struck out "rural, large urban, or other urban area" and substituted "large urban or other area", effective October 1, 1994.

[**] P.L. 101-403, §115(b)(1), struck out "September 30" and substituted "October 20", effective October 1, 1990.

See Vol. II, P.L. 101-403, §115(b)(2), with respect to adjustments in payments to hospitals.

[1226] As in original; one comma should be deleted.

[1227] See Vol. II, P.L. 99-509, §9307(d) [as amended by P.L. 100-203, §4008(e)], with respect to an accounting provision affecting some hospitals.

[1228] P.L. 101-239, §6004(a)(1)(A), struck out "or".

[1229] P.L. 101-239, §6004(a)(1)(B), struck out the semicolon and substituted ", or".

[1230] December 19, 1989.

[1231] P.L. 101-239, §6004(a)(1)(C), added clause (v). For the effective date, see Vol. II, P.L. 101-239, §6004(a)(3).

(i) on or after October 1, 1984, and before October 1, 1986, is a combined rate consisting of 25 percent of the national adjusted DRG prospective payment rate, and 75 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges; and

(ii) on or after October 1, 1986, and before October 1, 1987, is a combined rate consisting of 50 percent of the national adjusted DRG prospective payment rate, and 50 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges.

(2) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which payment may be made under part A of this title. Each such rate shall be determined for hospitals located in urban or rural areas within the United States or within each such region, respectively, as follows:

(A) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

(B) UPDATING FOR FISCAL YEAR 1984.—The Secretary shall update each amount determined under subparagraph (A) for fiscal year 1984 by—

(i) updating for fiscal year 1983 by the estimated average rate of change of hospital costs industry-wide between the cost reporting period used under such subparagraph and fiscal year 1983 and the most recent case-mix data available, and

(ii) projecting for fiscal year 1984 by the applicable percentage increase (as defined in subsection (b)(3)(B)) for fiscal year 1984.

(C) STANDARDIZING AMOUNTS.—The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—

(i) excluding an estimate of indirect medical education costs (taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985[1232]),

(ii) adjusting for variations among hospitals by area in the average hospital wage level,

(iii) adjusting for variations in case mix among hospitals, and

(iv) for discharges occurring on or after October 1, 1986,[1233] excluding an estimate of the additional payments to certain hospitals to be made under paragraph (5)(F), except that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section 6003(c) of the Omnibus Budget Reconciliation Act of 1989 or the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990[1234].[1235]

[1232] P.L. 99-272; Title IX.

[1233] P.L. 101-508, §4002(b)(3)(A), struck out "and before October 1, 1995,", applicable to discharges occurring on or after January 1, 1991.

(D) Computing urban and rural averages.—The Secretary shall compute an average of the standardized amounts determined under subparagraph (C) for the United States and for each region—

(i) for all subsection (d) hospitals located in an urban area within the United States or that region, respectively, and

(ii) for all subsection (d) hospitals located in a rural area within the United States or that region, respectively.

For purposes of this subsection, the term "region" means one of the nine census divisions, comprising the fifty States and the District of Columbia, established by the Bureau of the Census[1236] for statistical and reporting purposes; the term "urban area" means an area within a Metropolitan Statistical Area (as defined by the Office of Management and Budget) or within such similar area as the Secretary has recognized under subsection (a) by regulation; the term "large urban area" means, with respect to a fiscal year, such an urban area which the Secretary determines (in the publications described in subsection (e)(5) before the fiscal year) has a population of more than 1,000,000 (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census); and the term "rural area" means any area outside such an area or similar area. A hospital located in a Metropolitan Statistical Area shall be deemed to be located in the region in which the largest number of the hospitals in the same Metropolitan Statistical Area are located, or, at the option of the Secretary, the region in which the majority of the inpatient discharges (with respect to which payments are made under this title) from hospitals in the same Metropolitan Statistical Area are made.[1237]

(E) Reducing for value of outlier payments.—The Secretary shall reduce each of the average standardized amounts determined under subparagraph (D) by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment rates which are additional payments described in paragraph (5)(A) (relating to outlier payments).

(F) Maintaining budget neutrality.—The Secretary shall adjust each of such average standardized amounts as may be required under subsection (e)(1)(B) for that fiscal year.

(G) Computing DRG-specific rates for urban and rural hospitals in the United States and in each region.—For each discharge classified within a diagnosis-related group, the Secretary shall establish a national DRG prospective payment rate and shall establish a regional DRG prospective payment rate for each region, each of which is equal—

[1234] P.L. 101-508, §4002(b)(4)(B), inserted "or the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990", applicable to discharges occurring on or after January 1, 1991.

[1235] P.L. 101-508, §4002(b)(4)(A), struck out a period and substituted ", except that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section 6003(c) of the Omnibus Budget Reconciliation Act of 1989.", effective as if included in the enactment of P.L. 101-239.

[1236] Department of Commerce.

[1237] See Vol. II, P.L. 100-203, §4009(i), with respect to New England county metropolitan areas.

(i) for hospitals located in an urban area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (D), reduced under subparagraph (E), and adjusted under subparagraph (F)) for hospitals located in an urban area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group; and

(ii) for hospitals located in a rural area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (D), reduced under subparagraph (E), and adjusted under subparagraph (F)) for hospitals located in a rural area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(H) Adjusting for different area wage levels.—The Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the national and regional DRG prospective payment rates computed under subparagraph (G) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

(3) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in a fiscal year after fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region for which payment may be made under part A of this title. Each such rate shall be determined for hospitals located in large urban, other urban, or rural areas within the United States and within each such region, respectively, as follows:

(A) Updating previous standardized amounts.—(i) For discharges occurring in a fiscal year beginning before October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph, increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B). With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).[1238]

(ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994,[1239] the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.[1240]

(iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an other urban area.[1241]

(iv) For discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.[1242]

(v)[1243] Average standardized amounts computed under this paragraph shall be adjusted to reflect the most recent case-mix data available.[1244]

(B) REDUCING FOR VALUE OF OUTLIER PAYMENTS.—The Secretary shall reduce each of the average standardized amounts determined under subparagraph (A) by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments).[1245]

(C)(i) MAINTAINING BUDGET NEUTRALITY FOR FISCAL YEAR 1985.—For discharges occurring in fiscal year 1985, the Secretary shall adjust each of such average standardized amounts as may be required under subsection (e)(1)(B) for that fiscal year.

(ii) REDUCING FOR SAVINGS FROM AMENDMENT TO INDIRECT TEACHING ADJUSTMENT FOR DISCHARGES AFTER SEPTEMBER 30,

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[1238] See Vol. II, P.L. 99-509, §9321(c)(2), with respect to exclusion of capital-related regulations.

[1239] P.L. 101-508, §4002(c)(2)(B)(ii)(I), inserted "and ending on or before September 30, 1994,", effective October 1, 1994.

[1240] See Vol. II, P.L. 100-203, §4002(g)(5), with respect to the transition for large urban area rates.

[1241] P.L. 101-508, §4002(c)(2)(B)(ii)(III), added a new clause (iii), effective October 1, 1994.

[1242] P.L. 101-508, §4002(c)(2)(B)(ii)(III), added clause (iv), effective October 1, 1994.

[1243] P.L. 101-508, §4002(c)(2)(B)(ii)(II), redesignated clause (iii) as clause (v), effective October 1, 1994.

[1244] See Vol. II, P.L. 100-203, §4002(g)(5), with respect to the transition for large urban area rates.

[1245] P.L. 101-508, §4002(c)(2)(B)(iii), struck out "for hospitals located in an urban area and for hospitals located in a rural area by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments) for hospitals located in such respective area." and substituted "by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments).", effective October 1, 1994.

1986.—For discharges occurring after September 30, 1986, the Secretary shall further reduce each of the average standardized amounts (in a proportion which takes into account the differing effects of the standardization effected under paragraph (2)(C)(i)) so as to provide for a reduction in the total of the payments (attributable to this paragraph) made for discharges occurring on or after October 1, 1986, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985[1246] and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987[1247] if the factor described in clause (ii)(II) of paragraph (5)(B) (determined without regard to amendments made by the Omnibus Budget Reconciliation Act of 1990[1248]) were applied for discharges occurring on or after such date instead of the factor described in clause (ii) of that paragraph.[1249]

(D) COMPUTING DRG-SPECIFIC RATES FOR HOSPITALS IN DIFFERENT AREAS.—For each discharge classified within a diagnosis-related group, the Secretary shall establish for the fiscal year a national DRG prospective payment rate and shall establish a regional DRG prospective payment rate for each region, each of which is equal—

(i) for hospitals located in a large urban area[1250] in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C)) for the fiscal year for hospitals located in such a large urban area[1251] in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group; and

(ii) for hospitals located in other areas[1252] in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C)) for the fiscal year for hospitals located in other areas[1253] in the United States or that region, and

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[1246] P.L. 99-272; Title IX

[1247] P.L. 100-203.

[1248] P.L. 100-508.

[1249] P.L. 101-508, §4002(b)(3)(B), struck out "occurring—" and subclauses (I)-(II) and substituted "occurring on or after October 1, 1986, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985 and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987 if the factor described in clause (ii)(II) of paragraph (5)(B) (determined without regard to amendments made by the Omnibus Budget Reconciliation Act of 1990) were applied for discharges occurring on or after such date instead of the factor described in clause (ii) of that paragraph.", applicable to discharges occurring on or after January 1, 1991. [For subclauses (I) and (II) as they formerly read, see Vol. III, P.L. 101-508.]

[1250] P.L. 101-508, §4002(c)(2)(B)(iv)(I), struck out "an urban area (or, for discharges occurring on or after April 1, 1988, in a large urban area or other urban area),*" and substituted "a large urban area", effective October 1, 1994.

*There was no comma after "area)".

[1251] P.L. 101-508, §4002(c)(2)(B)(iv)(II), struck out "an urban area" and substituted "a large urban area", effective October 1, 1994.

[1252] P.L. 101-508, §4002(c)(2)(B)(v), struck out "a rural area" and substituted "other areas", effective October 1, 1994.

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(E) Adjusting for different area wage levels.—The Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the DRG prospective payment rates computed under subparagraph (D) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. Not later than October 1, 1990, and October 1, 1993 (and at least every 12[1254] months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs of subsection (d) hospitals in the United States. To the extent determined feasible by the Secretary, such survey shall measure the earnings and paid hours of employment by occupational category and shall exclude data with respect to the wages and wage-related costs incurred in furnishing skilled nursing facility services. Any adjustments or updates made under this subparagraph for a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.[1255]

(4)(A) The Secretary shall establish a classification of inpatient hospital discharges by diagnosis-related groups and a methodology for classifying specific hospital discharges within these groups.

(B) For each such diagnosis-related group the Secretary shall assign an appropriate weighting factor which reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

(C)(i)[1256] The Secretary shall adjust the classifications and weighting factors established under subparagraphs (A) and (B), for discharges in fiscal year 1988 and at least annually thereafter, to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources.

(ii) For discharges in fiscal year 1990, the Secretary shall reduce the weighting factor for each diagnosis-related group by 1.22 percent.[1257]

[1253] P.L. 101-508, §4002(c)(2)(B)(v), struck out "a rural area" and substituted "other areas", effective October 1, 1994.

[1254] P.L. 101-239, §6003(h)(6)(A), struck out "(and at least every 36" and substituted ", and October 1, 1993 (and at least every 12", effective December 19, 1989.

[1255] P.L. 101-239, §6003(h)(6)(B), added this sentence, effective December 19, 1989.

See Vol. II, P.L. 98-369, §2316, with respect to adjustment of the payment amounts for certain hospital discharges.

See Vol. II, P.L. 101-239, §6003(h)(5), with respect to additional payment resulting from corrections of erroneously determined wage index.

See Vol. II, P.L. 101-508, §4002(d), with respect to the area wage index, and §4002(e)(2), with respect to a study and report required.

See Vol. II, P.L. 101-403, §115(a), with respect to extension of the area wage index.

[1256] P.L. 101-239, §6003(b)(1), inserted "(i)".

[1257] P.L. 101-239, §6003(b)(2), added clause (ii), effective December 19, 1989.

(iii) Any such adjustment under clause (i) for discharges in a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection for discharges in the fiscal year are not greater or less than those that would have been made for discharges in the year without such adjustment.[1258]

(iv) The Secretary shall include recommendations with respect to adjustments to weighting factors under clause (i) in the annual report to Congress required under subsection (e)(3)(B).[1259]

[(D) Stricken.[1260]]

(5)(A)(i) The Secretary shall provide for an additional payment for a subsection (d) hospital for any discharge in a diagnosis-related group, the length of stay of which exceeds the mean length of stay for discharges within that group by a fixed number of days, or exceeds such mean length of stay by some fixed number of standard deviations, whichever is the fewer number of days.

(ii) For cases which are not included in clause (i), a subsection (d) hospital may request additional payments in any case where charges, adjusted to cost, exceed a fixed multiple of the applicable DRG prospective payment rate, or exceed such other fixed dollar amount, whichever is greater.

(iii) The amount of such additional payment under clauses (i) and (ii) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i) or (ii).

(iv) The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

(B) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:

(i) The amount of such additional payment shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and the amount paid to the hospital under subparagraph (A), by (II) the indirect teaching adjustment factor described in clause (ii).

(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor for discharges occurring on or after May 1, 1986, is equal to 1.89 × (((1+r) to the nth power) − 1), where "r" is the ratio of the hospital's full-time equivalent interns and residents to beds and "n" equals .405.[1261]

(iii) In determining such adjustment the Secretary shall not distinguish between those interns and residents who are employees of a hospital and those interns and residents who furnish services to a hospital but are not employees of such hospital.

[1258] P.L. 101-239, §6003(b)(2), added clause (iii), effective December 19, 1989.

[1259] P.L. 101-239, §6003(b)(2), added clause (iv), effective December 19, 1989.

[1260] P.L. 101-508, §4002(g)(2)(A), struck out subparagraph (D), effective November 5, 1990. [For subparagraph (D) as it formerly read, see Vol. III, P.L. 101-508.]

[1261] P.L. 101-508, §4002(b)(3)(B)(A)(sic), amended clause (ii) in its entirety, applicable to discharges occurring on or after January 1, 1991. [For clause (ii) as it formerly read, see Vol. III, P.L. 101-508.]

(iv) In determining such adjustment, the Secretary shall continue to count interns and residents assigned to outpatient services of the hospital as part of the calculation of the full-time-equivalent number of interns and residents.

(C)(i)[1262] The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection (other than under paragraph (9)) as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 275 or more beds located in rural areas). A hospital which is classified as a rural hospital may appeal to the Secretary to be classified as a rural referral center under this clause on the basis of criteria (established by the Secretary) which shall allow the hospital to demonstrate that it should be so reclassified by reason of certain of its operating characteristics being similar to those of a typical urban hospital located in the same census region and which shall not require a rural osteopathic hospital to have more than 3,000 discharges in a year in order to be classified as a rural referral center. Such characteristics may include wages, scope of services, service area, and the mix of medical specialties. The Secretary shall publish the criteria not later than August 17, 1984, for implementation by October 1, 1984. An appeal allowed under this clause must be submitted to the Secretary (in such form and manner as the Secretary may prescribe) during the quarter before the first quarter of the hospital's cost reporting period (or, in the case of a cost reporting period beginning during October 1984, during the first quarter of that period), and the Secretary must make a final determination with respect to such appeal within 60 days after the date the appeal was submitted. Any payment adjustments necessitated by a reclassification based upon the appeal shall be effective at the beginning of such cost reporting period.[1263]

(ii)[1264] The Secretary shall provide, under clause (i)[1265], for the classification of a rural hospital as a regional referral center if the hospital has a case mix index equal to or greater than the median case mix index for hospitals (other than hospitals with approved teaching programs) located in an urban area in the same region (as defined in paragraph (2)(D)), has at least 5,000 discharges a year or, if less, the median number of discharges in urban hospitals in the region in which the hospital is located (or, in the case of a rural osteopathic hospital, meets the criterion established by the Secretary under clause (i)[1266] with respect to the annual number of discharges for such hospitals), and meets any other criteria established by the Secretary under clause (i)[1267]. [1268]

[1262] P.L. 101-239, §6003(e)(2)(B)(i), struck out "(I)".

[1263] See Vol. II, P.L. 99-509, §9302(d)(2), with respect to the extension of the regional referral center classification, and (d)(3), with respect to budget-neutral implementation.

[1264] P.L. 101-239, §6003(e)(2)(B)(ii), redesignated subclause (II) as clause (ii).

[1265] P.L. 101-239, §6003(e)(2)(B)(ii), struck out "subclause (I)" and substituted "clause (i)", effective December 19, 1989.

[1266] P.L. 101-239, §6003(e)(2)(B)(ii), struck out "subclause (I)" and substituted "clause (i)", effective December 19, 1989.

[1267] P.L. 101-239, §6003(e)(2)(B)(ii), struck out "subclause (I)" and substituted "clause (i)", effective December 19, 1989.

[1268] P.L. 101-239, §6003(d), provides that any hospital that is classified as a regional referral center under this subparagraph as of September 30, 1989, including a hospital so classified as a result of P.L. 99-509, §9302(d)(2), shall continue to be classified as a regional referral center for cost reporting periods beginning on or after October 1, 1989, and before October 1, 1992.

(D)(i) For any cost reporting period beginning on or after April 1, 1990, with respect to a subsection (d) hospital which is a sole community hospital, payment under paragraph (1)(A) shall be—

(I) an amount based on 100 percent of the hospital's target amount for the cost reporting period, as defined in subsection (b)(3)(C), or

(II) the amount determined under paragraph (1)(A)(iii),

whichever results in greater payment to the hospital.

(ii) In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

(iii) For purposes of this title, the[1269] term "sole community hospital" means any hospital—

(I) that the Secretary determines is located more than 35 road miles from another hospital,[1270]

(II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A, or[1271]

(III) that is designated by the Secretary as an essential access community hospital under section 1820(i)(1).[1272]

(iv) The Secretary shall promulgate a standard for determining whether a hospital meets the criteria for classification as a sole community hospital under clause (iii)(II) because of the time required for an individual to travel to the nearest alternative source of appropriate inpatient care.[1273]

(v) If the Secretary determines that, in the case of a hospital designated by the Secretary as an essential access community hospital under section 1820(i)(1), the hospital has incurred increases in reasonable costs during a cost reporting period as a result of becoming a member of a rural health network (as defined in section 1820(g)) in the State in which it is located, and in incurring such increases, the hospital will increase its costs for subsequent cost

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See Vol. II, P.L. 99-509, §9302(d)(3), with respect to budget-neutral implementation.

See Vol. II, P.L. 100-203, §4005(d)(2), with respect to the study which the Secretary is required to make and report on to Congress.

[1269] P.L. 101-508, §4008(m)(2)(A), struck out "The" and substituted "For purposes of this title, the", effective November 5, 1990.

[1270] P.L. 101-239, §6003(g)(2)(A)(i), struck out "or".

[1271] P.L. 101-239, §6003(g)(2)(A)(ii), struck out the period and substituted ", or".

[1272] P.L. 101-239, §6003(g)(2)(A)(iii), added subclause (III), effective December 19, 1989.

[1273] P.L. 101-239, §6003(e)(1)(A)(iv), redesignated §1886(d)(5)(C)(ii) as subparagraph (D) and amended it in its entirety, effective December 19, 1989. [For §1886(d)(5)(C)(ii) as it formerly read, see Vol. III, P.L. 101-239.]

P.L. 101-239, §6003(e)(3), provides that any hospital classified as a sole community hospital under §1886(d)(5)(C)(ii) on December 19, 1989, that will no longer be classified as a sole community hospital after that date as a result of the amendments made by P.L. 101-239, §6003(e)(1), shall continue to be classified as a sole community hospital for purposes of this subparagraph.

reporting periods, the Secretary shall increase the hospital's target amount under subsection (b)(3)(C) to account for such incurred increases.[1274]

(E)[1275](i) The Secretary shall estimate the amount of reimbursement made for services described in section 1862(a)(14) with respect to which payment was made under part B in the base reporting periods referred to in paragraph (2)(A) and with respect to which payment is no longer being made.

(ii) The Secretary shall provide for an adjustment to the payment for subsection (d) hospitals in each fiscal year so as appropriately to reflect the net amount described in clause (i).

(F)(i) For discharges occurring on or after May 1, 1986,[1276] the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which—

(I) serves a significantly disproportionate number of low-income patients (as defined in clause (v)), or

(II) is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this title or State plans approved under title XIX), during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of such net inpatient care revenues during the period.

(ii) The amount of such payment for each discharge shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and the amount paid to the hospital under subparagraph (A) for that discharge, by (II) the disproportionate share adjustment percentage established under clause (iii) or (iv) for the cost reporting period in which the discharge occurs.

(iii) The disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (i)(II) is equal to 35[1277] percent.

(iv) The disproportionate share adjustment percentage for a cost reporting period for a hospital that is not described in clause (i)(II) and that—

(I) is located in an urban area and has 100 or more beds or is described in the second sentence of clause (v), is equal to the percent determined in accordance with the applicable formula described in clause (vii)[1278];

(II) is located in an urban area and has less than 100 beds, is equal to 5 percent;[1279]

[1274] P.L. 101-239, §6003(g)(2)(B), added clause (v), effective December 19, 1989.

[1275] P.L. 99-509, §9320(g)(2), struck out a former subparagraph (E), applicable to services furnished on or after January 1, 1989. For the applicability of this amendment, see Vol. II, P.L. 99-509, §9320(k), as added by P.L. 100-485 and amended by P.L. 101-239.

P.L. 101-239, §6003(e)(1)(A)(iii), redesignated subparagraph (D) as subparagraph (E).

[1276] P.L. 101-508, §4002(b)(3)(A), struck out "and before October 1, 1995,", applicable to discharges occurring on or after January 1, 1991.

[1277] P.L. 101-239, §6003(c)(3), struck out "25" and substituted "30", applicable to discharges occurring on or after April 1, 1990.

P.L. 101-508, §4002(b)(2), struck out "30" and substituted "35", applicable to discharges occurring on or after October 1, 1991.

[1278] P.L. 101-239, §6003(c)(1)(A), struck out "following formula: (P - 15)(.5) + 2.5, where 'P' is the hospital's disproportionate patient percentage (as defined in clause (vi))" and substituted "applicable formula described in clause (vii)", applicable to discharges occurring on or after April 1, 1990.

[1279] P.L. 101-239, §6003(c)(2)(A)(i), struck out "or".

(III) is located in a rural area and is not described in subclause (IV) or (V) or[1280] in the second sentence of clause (v), is equal to 4 percent;[1281]

(IV) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is classified as a sole community hospital under subparagraph (D), is equal to 10 percent or, if greater, the percent determined in accordance with the applicable formula described in clause (viii);[1282]

(V) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is not classified as a sole community hospital under subparagraph (D), is equal to the percent determined in accordance with the applicable formula described in clause (viii); or[1283]

(VI) is located in a rural area, is classified as a sole community hospital under subparagraph (D), and is not classified as a rural referral center under subparagraph (C), is 10 percent.[1284]

(v) In this subparagraph, a hospital "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals, or exceeds—

(I) 15 percent, if the hospital is located in an urban area and has 100 or more beds,

(II) 30 percent, if the hospital is located in a rural area and has more than 100 beds, or is located in a rural area and is classified as a sole community hospital under subparagraph (D),[1285]

(III)[1286] 40 percent, if the hospital is located in an urban area and has less than 100 beds, or

(IV)[1287] 45 percent, if the hospital is located in a rural area and is not described in subclause (II)[1288].

A hospital located in a rural area and with 500 or more beds also "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary.

(vi) In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—

(I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this title and were entitled to supplementary security income benefits (excluding any State supplementation) under title XVI of this Act, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this title, and

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[1280] P.L. 101-239, §6003(c)(2)(A)(ii), inserted "in subclause (IV) or (V) or", applicable to discharges occurring on or after April 1, 1990.

[1281] P.L. 101-239, §6003(c)(2)(A)(iii), struck out the period and substituted a semicolon.

[1282] P.L. 101-239, §6003(c)(2)(A)(iv), added subclause (IV), applicable to discharges occurring on or after April 1, 1990.

[1283] P.L. 101-239, §6003(c)(2)(A)(iv), added subclause (V), applicable to discharges occurring on or after April 1, 1990.

[1284] P.L. 101-239, §6003(c)(2)(A)(iv), added subclause (VI), applicable to discharges occurring on or after April 1, 1990.

[1285] P.L. 101-239, §6003(c)(2)(B)(iii), added this subclause (II), applicable to discharges occurring on or after April 1, 1990.

[1286] P.L. 101-239, §6003(c)(2)(B)(ii), redesignated the former subclause (II) as subclause (III).

[1287] P.L. 101-239, §6003(c)(2)(B)(ii), redesignated subclause (III) as subclause (IV).

[1288] P.L. 101-239, §6003(c)(2)(B)(i), inserted "and is not described in subclause (II)", applicable to discharges occurring on or after April 1, 1990.

(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, but who were not entitled to benefits under part A of this title, and the denominator of which is the total number of the hospital's patient days for such period.

(vii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(I) is—

(I) in the case of such a hospital with a disproportionate patient percentage (as defined in clause (vi)) greater than 20.2—

(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, (P-20.2)(.65)+5.62,

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, (P-20.2)(.7)+5.62,

(c) for discharges occurring on or after October 1, 1993, and on or before September 30, 1994, (P-20.2)(.8)+5.88, and

(d) for discharges occurring on or after October 1, 1994, (P-20.2)(.825)+5.88; or[1289]

(II) in the case of any other such hospital—

(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, (P-15)(.6)+2.5,

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, (P-15)(.6)+2.5,

(c) for discharges occurring on or after October 1, 1993, (P-15)(.65)+2.5,[1290]

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).[1291]

(viii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(IV) or (iv)(V) is the percentage determined in accordance with the following formula: (P-30)(.6)+4.0, where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).[1292]

(G)(i) For any cost reporting period beginning on or after April 1, 1990, and ending on or before March 31, 1993, with respect to a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be—

(I) an amount based on 100 percent of the hospital's target amount for the cost reporting period, as defined in subsection (b)(3)(D), or

(II) the amount determined under paragraph (1)(A)(iii),

whichever results in the greater payment to the hospital.

[1289] P.L. 101-508, §4002(b)(1)(A), struck out "greater than 20.2, (P-20.2)(.65)+5.62, or" and substituted "greater than 20.2—" and (a)-(d), applicable to discharges occurring on or after January 1, 1991.

[1290] P.L. 101-508, §4002(b)(1)(B), struck out "hospital, (P-15)(.6)+2.5," and substituted "hospital—" and (a)-(c), applicable to discharges occurring on or after January 1, 1991.

[1291] P.L. 101-239, §6003(c)(1)(B), added clause (vii), applicable to discharges occurring on or after April 1, 1990.

[1292] P.L. 101-239, §6003(c)(2)(C), added clause (viii), applicable to discharges occurring on or after April 1, 1990.

(ii) In the case of a medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

(iii) The term "medicare-dependent, small rural hospital" means, with respect to any cost reporting period to which clause (i) applies, any hospital—

(I) located in a rural area,

(II) that has not more than 100 beds,

(III) that is not classified as a sole community hospital under subparagraph (D), and

(IV) for which not less than 60 percent of its inpatient days or discharges during the cost reporting period beginning in fiscal year 1987 were attributable to inpatients entitled to benefits under part A.[1293]

(H)[1294] The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(I)[1295] The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate[1296].

(6) The Secretary shall provide for publication in the Federal Register, on or before the September 1 before each fiscal year (beginning with fiscal year 1984), of a description of the methodology and data used in computing the adjusted DRG prospective payment rates under this subsection, including any adjustments required under subsection (e)(1)(B).

(7) There shall be no administrative or judical review under section 1878 or otherwise of—

(A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1), and

(B) the establishment of diagnosis-related groups, of the methodology for the classification of discharges within such groups, and of the appropriate weighting factors thereof under paragraph (4).[1297]

(8)(A) In the case of any hospital which is located in an area which is, at any time after April 20, 1983, reclassified from an urban to a rural area, payments to such hospital for the first two cost reporting periods for which such reclassification is effective shall be made as follows:

[1293] P.L. 101-239, §6003(f)(1), added subparagraph (G), effective December 19, 1989.

[1294] P.L. 101-239, §6003(e)(1)(A)(i), redesignated clause (iv) of subparagraph (C) as subparagraph (H), effective December 19, 1989.

[1295] P.L. 101-239, §6003(e)(1)(A)(ii), redesignated clause (iii) of subparagraph (C) as subparagraph (I), effective December 19, 1989.

[1296] P.L. 101-239, §6004(a)(2), struck out "(including exceptions and adjustments that may be appropriate with respect to hospitals involved extensively in treatment for and research on cancer)". For the effective date, see Vol. II, P.L. 101-239, §6004(a)(3).

[1297] See Vol. II, P.L. 98-21, §601(g) with respect to determining whether a hospital is in an urban or rural area, and §604(b) with respect to a reduction in the payment amount under certain conditions.

(i) For the first such cost reporting period, payment shall be equal to the amount payable to such hospital for such reporting period on the basis of the rural classification, plus an amount equal to two-thirds of the amount (if any) by which—

(I) the amount which would have been payable to such hospital for such reporting period on the basis of an urban classification, exceeds

(II) the amount payable to such hospital for such reporting period on the basis of the rural classification.

(ii) For the second such cost reporting period, payment shall be equal to the amount payable to such hospital for such reporting period on the basis of the rural classification, plus an amount equal to one-third of the amount (if any) by which—

(I) the amount which would have been payable to such hospital for such reporting period on the basis of an urban classification, exceeds

(II) the amount payable to such hospital for such reporting period on the basis of the rural classification.[1298]

(B) For purposes of this subsection, the Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area, under the standards for designating Metropolitan Statistical Areas (and for designating New England County Metropolitan Areas) published in the Federal Register on January 3, 1980, if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous Metropolitan Statistical Areas (or New England County Metropolitan Areas).

(C)(i) If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as being located in an urban area, or by treating hospitals located in one urban area as being located in another urban area—[1299]

(I) reduces the wage index for that urban area (as applied under this subsection) by 1 percentage point or less, the Secretary, in calculating such wage index under this subsection, shall exclude those hospitals so treated, or

(II) reduces the wage index for that urban area by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so treated) and to the hospitals so treated (as if such hospitals were located in such urban area).[1300]

[1298] See Vol. II, P.L. 98-21, §601(g) with respect to determining whether a hospital is in an urban or rural area; §603 with respect to reports, experiments, and demonstration projects; and §604(b) with respect to a reduction in the payment amount under certain conditions.

See Vol. II, P.L. 98-369, §2316, with respect to development of a prospective payment wage index and report to Congress.

[1299] P.L. 101-508, §4002(h)(1)(A)(i), struck out "area—" and substituted "area, or by treating hospitals located in one urban area as being located in another urban area—", applicable to discharges occurring on or after January 1, 1991.

(ii)[1301] If the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10), by treating hospitals located in a rural county or counties as not being located in the rural area in a State, reduces the wage index for that rural area (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection as if the hospitals so treated had not been excluded from calculation of the wage index for that rural area.[1302]

(iii)[1303] The application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) may not result in the reduction of any county's wage index to a level below the wage index for rural areas in the State in which the county is located.[1304]

(D) The Secretary shall make a proportional adjustment in the standardized amounts determined under paragraph (3)[1305] to assure that the provisions of subparagraphs (B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10)[1306] do not result in aggregate payments under this section that are greater or less than those that would otherwise be made.[1307]

(9)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges in a fiscal year beginning on or after October 1, 1987, is equal to the sum of—

(i) 75 percent of the Puerto Rico adjusted DRG prospective payment rate (determined under subparagraph (B) or (C)) for such discharges, and

(ii) 25 percent of the discharge-weighted average of—

[1300] P.L. 101-508, §4002(h)(1)(A)(ii), amended clause (i)(II) in its entirety, applicable to discharges occurring on or after January 1, 1991. [For clause (i)(II) as it formerly read, see Vol. III, P.L. 101-508.]

[1301] P.L. 101-508, §4002(h)(1)(A)(iii), struck out clause (ii), applicable to discharges occurring on or after January 1, 1991. [For clause (ii) as it formerly read, see Vol. III, P.L. 101-508.]

P.L. 101-508, §4002(h)(1)(A)(iv), redesignated clause (iii) as clause (ii), applicable to discharges occurring on or after January 1, 1991.

[1302] P.L. 101-239, §6003(h)(3), amended subparagraph (C) in its entirety, applicable to discharges occurring on or after April 1, 1990. [For subparagraph (C) as it formerly read, see Vol. III, P.L. 101-239.]

[1303] P.L. 101-508, §4002(h)(1)(A)(iv), redesignated clause (iv) as clause (iii), applicable to discharges occurring on or after January 1, 1991.

[1304] P.L. 101-239, §6003(h)(4), added clause (iv), applicable to discharges occurring on or after April 1, 1990.

[1305] P.L. 101-508, §4002(c)(2)(B)(vi)(I), struck out "for hospitals located in an urban area", effective October 1, 1994.

[1306] P.L. 101-239, §6003(h)(2)(B), inserted "or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10)", effective December 19, 1989.

[1307] P.L. 101-508, §4002(c)(2)(B)(vi)(II), struck out "The Secretary shall make such adjustment in payments under this section to hospitals located in rural areas as are necessary to assure that the aggregate of payments to rural hospitals not affected by subparagraphs (B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10)* are not changed as a result of the application of subparagraphs (B) and (C) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10)**.", effective October 1, 1994.

*P.L. 101-239, §6003(h)(2)(B), inserted "or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10)", effective December 19, 1989.

**P.L. 101-239, §6003(h)(2)(B), inserted "or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10)", effective December 19, 1989.

(I) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in a large urban area,

(II) such rate for hospitals located in other urban areas, and

(III) such rate for hospitals located in a rural area,

for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels. As used in this section, the term "subsection (d) Puerto Rico hospital" means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the fifty States.

(B) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for such hospitals located in urban or rural areas within Puerto Rico, as follows:

(i) The Secretary shall determine the target amount (as defined in subsection (b)(3)(A)) for the hospital for the cost reporting period beginning in fiscal year 1987 and increase such amount by prorating the applicable percentage increase (as defined in subsection (b)(3)(B)) to update the amount to the midpoint in fiscal year 1988.

(ii) The Secretary shall standardize the amount determined under clause (i) for each hospital by—

(I) excluding an estimate of indirect medical education costs,

(II) adjusting for variations among hospitals by area in the average hospital wage level,

(III) adjusting for variations in case mix among hospitals, and

(IV) excluding an estimate of the additional payments to certain subsection (d) Puerto Rico hospitals to be made under subparagraph (D)(iii)[1308] (relating to disproportionate share payments).

(iii) The Secretary shall compute a discharge weighted average of the standardized amounts determined under clause (ii) for all hospitals located in an urban area and for all hospitals located in a rural area (as such terms are defined in paragraph (2)(D)).

(iv) The Secretary shall reduce the average standardized amount by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

(v) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

(I) the average standardized amount (computed under clause (iii) and reduced under clause (iv)) for hospitals located in an urban or rural area, respectively, and

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[1308] P.L. 101-239, §6003(e)(2)(C), struck out "(D)(v)" and substituted "(D)(iii)", effective December 19, 1989.

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(vi) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (v) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level.

(C) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge after fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for hospitals located in urban or rural areas within Puerto Rico as follows:

(i) The Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area equal to the respective average standardized amount computed for the previous fiscal year under subparagraph (B)(iii) or under this clause, increased for fiscal year 1989 by the applicable percentage increase under subsection (b)(3)(B), and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4), and adjusted to reflect the most recent case-mix data available.

(ii) The Secretary shall reduce each of the average standardized amounts by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

(iii) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

(I) the average standardized amount (computed under clause (i) and reduced under clause (ii)) for hospitals located in an urban or rural area, respectively, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(iv) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (iii) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rico average hospital wage level. The second and third sentences of paragraph (3)(E) shall apply to subsection (d) Puerto Rico hospitals under this clause in the same manner as they apply to subsection (d) hospitals under such paragraph and, for purposes of this clause, any reference in such paragraph to a subsection (d) hospital is deemed a reference to a subsection (d) Puerto Rico hospital.

(D) The following provisions of paragraph (5) shall apply to subsection (d) Puerto Rico hospitals receiving payment under this paragraph in the same manner and to the extent as they apply to subsection (d) hospitals receiving payment under this subsection:

(i) Subparagraph (A) (relating to outlier payments).

(ii) Subparagraph (B) (relating to payments for indirect medical education costs), except that for this purpose the sum of the amount determined under subparagraph (A) of this paragraph and the amount paid to the hospital under clause (i) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(B)(i)(I).

(iii)[1309] Subparagraph (F) (relating to disproportionate share payments), except that for this purpose the sum described in clause (ii) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(F)(ii)(I).

(iv)[1310] Subparagraph (H)[1311] (relating to exceptions and adjustments).

(10)(A) There is hereby established the Medicare Geographic[1312] Classification Review Board (hereinafter in this paragraph referred to as the "Board").

(B)(i) The Board shall be composed of 5 members appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. Two of such members shall be representative[1313] of subsection (d) hospitals located in a rural area under paragraph (2)(D). At least[1314] 1 member shall be knowledgeable in the field of analyzing costs with respect to the provision of inpatient hospital services.

(ii) The Secretary shall make initial[1315] appointments to the Board as provided in this paragraph within 180 days after the date of the enactment of this paragraph[1316].

(C)(i) The Board shall consider the application of any subsection (d) hospital requesting that the Secretary change the hospital's geographic classification for purposes of determining for a fiscal year—

(I) the hospital's average standardized amount under paragraph (2)(D), or

(II) the area wage index applicable to such hospital under paragraph (3)(E).

(ii) A hospital requesting a change in geographic classification under clause (i) for a fiscal year shall submit its application to the Board not later than the first day of the preceding fiscal year.

(iii)(I) The Board shall render a decision on an application submitted under clause (i) not later than 180 days after the deadline referred to in clause (ii).

[1309] P.L. 101-239, §6003(e)(2)(D)(iii), redesignated clause (v) as clause (iii).

[1310] P.L. 101-239, §6003(e)(2)(D)(i), struck out clause (iv) and §6003(e)(2)(D)(ii) redesignated clause (iii) as clause (iv), effective December 19, 1989. [For clause (iv) as it formerly read, see Vol. III, P.L. 101-239.]

[1311] P.L. 101-239, §6003(e)(2)(D)(ii), struck out "(C)(iii)" and substituted "(H)", effective December 19, 1989.

[1312] P.L. 101-508, §4002(h)(2)(B)(i), struck out "Geographical" and substituted "Geographic", effective November 5, 1990.

[1313] P.L. 101-508, §4002(h)(2)(B)(ii)(I), struck out "representatives" and substituted "representative", effective November 5, 1990.

[1314] P.L. 101-508, §4002(h)(2)(B)(ii)(II), struck out "1 member shall be a member of the Prospective Payment Assessment Commission, and at least", effective November 5, 1990.

[1315] P.L. 101-508, §4002(h)(2)(B)(iii), struck out "all" and substituted "initial", effective November 5, 1990.

[1316] December 19, 1989.

(II) Appeal of decisions of the Board shall be subject to the provisions of section 557b of title 5, United States Code.[1317] The Secretary shall issue a decision on such an appeal not later than 90 days after the date on which[1318] the appeal is filed. The decision of the Secretary shall be final and shall not be subject to judicial review.

(D)(i) The Secretary shall publish guidelines to be utilized by the Board in rendering decisions on applications submitted under this paragraph, and shall include in such guidelines the following:

(I) Guidelines for comparing wages, taking into account occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified.

(II) Guidelines for determining whether the county in which the hospital is located should be treated as being a part of a particular Metropolitan Statistical Area.

(III) Guidelines for considering information provided by an applicant with respect to the effects of the hospital's geographic classification on access to inpatient hospital services by medicare beneficiaries.

(IV) Guidelines for considering the appropriateness of the criteria used to define New England County Metropolitan Areas.

(ii) The Secretary shall publish the guidelines described in clause (i) by July 1, 1990.

(E)(i) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this paragraph. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d) and (e) of section 205 with respect to subpenas shall apply to the Board to the same extent as such provisions apply to the Secretary with respect to title II.

(ii) The Board is authorized to engage such technical assistance and to receive such information as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

(F)(i) Each member of the Board who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for grade GS-18 of the General Schedule under section 5332 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Board. Each member of the Board who is an officer or employee of the United States shall serve without compensation in addition to that received for service as an officer or employee of the United States.

(ii) Members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.[1319]

[1317] P.L. 101-508, §4002(h)(2)(B)(iv)(I), struck out "A decision of the Board shall be final unless the unsuccessful applicant appeals such decision to the Secretary by not later than 15 days after the Board renders its decision. The Secretary in considering the appeal of an applicant shall receive no new evidence but shall consider the record as a whole as such record appeared before the Board." and substituted "Appeal of decisions of the Board shall be subject to the provisions of section 557b of title 5, United States Code.", effective November 5, 1990.

[1318] P.L. 101-508, §4002(h)(2)(B)(iv)(II), struck out "after" and substituted "after the date on which", effective November 5, 1990.

(e)(1)(A) For cost reporting periods of hospitals beginning in fiscal year 1984 or fiscal year 1985, the Secretary shall provide for such proportional adjustment in the applicable percentage increase (otherwise applicable to the periods under subsection (b)(3)(B)) as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(I) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1866(a)(1)(F)),

are not greater or less than—

(ii) the target percentage (as defined in subsection (d)(1)(C)) of the payment amounts which would have been payable for such services for those same hospitals for that fiscal year under this section under the law as in effect before the date of the enactment of the Social Security Amendments of 1983[1320] (excluding payments made under section 1866(a)(1)(F));

except that the adjustment made under this subparagraph shall apply only to subsection (d) hospitals and shall not apply for purposes of making computations under subsection (d)(2)(B)(ii) or subsection (d)(3)(A).

(B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment in each of the average standardized amounts otherwise computed for that fiscal year as may be necessary to assure that—

(i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1866(a)(1)(F)),

are not greater or less than—

(ii) the DRG percentage (as defined in subsection (d)(1)(C)) of the payment amounts which would have been payable for such services for those same hospitals for that fiscal year under this section under the law as in effect before the date of the enactment of the Social Security Amendments of 1983[1321] (excluding payments made under section 1866(a)(1)(F)).

(C) For discharges occurring in fiscal year 1988, the Secretary shall provide for such equal proportional adjustment in each of the average standardized amounts otherwise computed under subsection (d)(3) for that fiscal year as may be necessary to assure that—

[1319] P.L. 101-239, §6003(h)(1), added paragraph (10), effective December 19, 1989.

See Vol. II, P.L. 99-509, §9305(e), with respect to a study of payment for administratively necessary days.

See Vol. II, P.L. 100-203, §4002(g)(6), for the meaning of "subsection (d) hospital"; §4003(d), with respect to a special rule for certain hospitals; §4004(b) with respect to calculating the clinic hospital wage index in the case of certain hospitals; §4009(h), with respect to studies and reports which the Prospective Payment Assessment Commission is required to make; and §4403(a), with respect to experiments and demonstration projects.

See Vol. II, P.L. 100-360, §104(c)(1) [as amended by P.L. 101-234], with respect to PPS hospitals.

See Vol. II, P.L. 100-647, §8403(b), with respect to the Secretary's report on adjustment of hospital wage indices for fiscal year 1989; and §8403(c), with respect to a ProPAC study and report.

See Vol. II, P.L. 101-239, §6003(i), with respect to a legislative proposal eliminating separate average standardized amounts; and §6003(j), with respect to a ProPAC study of payments to rural sole community hospitals and small rural hospitals.

See Vol. II, P.L. 101-508, §4002(h)(2)(A), with respect to a change in geographic classification.

[1320] April 20, 1983 [P.L. 98-21; 97 Stat. 65].

[1321] April 20, 1983 [P.L. 98-21; 97 Stat. 65].

(i) the aggregate payment amounts otherwise provided under subsections (d)(1)(A)(iii), (d)(5), and (d)(9) for that fiscal year for operating costs of inpatient hospital services of subsection (d) hospitals and subsection (d) Puerto Rico hospitals,

are not greater or less than—

(ii) the payment amounts that would have been payable for such services for those same hospitals for that fiscal year but for the enactment of the amendments made by section 9304 of the Omnibus Budget Reconciliation Act of 1986[1322].

(2)(A)[1323] The Director of the Congressional Office of Technology Assessment (hereinafter in this subsection referred to as the "Director" and the "Office", respectively) shall provide for appointment of a Prospective Payment Assessment Commission (hereinafter in this subsection referred to as the "Commission"), to be composed of independent experts appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service). The Commission[1324] shall review the applicable percentage increase factor described in subsection (b)(3)(B) and make recommendations to the Secretary on the appropriate percentage change which should be effected for hospital inpatient discharges under subsections (b) and (d) for fiscal years beginning with fiscal year 1986. In making its recommendations, the Commission shall take into account changes in the hospital market-basket described in subsection (b)(3)(B), hospital productivity, technological and scientific advances, the quality of health care provided in hospitals (including the quality and skill level of professional nursing required to maintain quality care), and long-term cost-effectiveness in the provision of inpatient hospital services.

(B) In order to promote the efficient and effective delivery of high-quality health care services, the Commission shall, in addition to carrying out its functions under subparagraph (A), study and make recommendations for each fiscal year regarding changes in each existing reimbursement policy under this title under which payments to an institution are based upon prospectively determined rates and the development of new institutional reimbursement policies under this title, including recommendations relating to payments during such fiscal year under the prospective payment system established under this section for determining payments for the operating costs of inpatient hospital services, including changes in the number of diagnosis-related groups used to classify inpatient hospital discharges under subsection (d), adjustments to such groups to reflect severity of illness, and changes in the methods by which hospitals are reimbursed for capital-related costs, together with general recommendations on the effectiveness and quality of health care delivery systems in the United States and the effects on such systems of institutional reimbursements under this title.[1325]

[1322] P.L. 99-509.

[1323] P.L. 101-508, §4002(g)(1)(A), redesignated paragraph (2) as paragraph (2)(A), effective November 5, 1990.

[1324] P.L. 101-508, §4002(g)(2)(B), struck out "In addition to carrying out its functions under subsection (d)(4)(D), the Commission" and substituted "The Commission", effective November 5, 1990.

[1325] P.L. 101-508, §4002(g)(1)(B), added subparagraph (B), effective November 5, 1990.

(C) By not later than June 1 of each year, the Commission shall submit a report to Congress containing an examination of issues affecting health care delivery in the United States, including issues relating to—

(i) trends in health care costs;

(ii) the financial condition of hospitals and the effect of the level of payments made to hospitals under this title on such condition;

(iii) trends in the use of health care services; and

(iv) new methods used by employers, insurers, and others to constrain growth in health care costs.[1326]

(3)(A) The Commission, not later than the March 1 before the beginning of each fiscal year (beginning with fiscal year 1986), shall report its recommendations to Congress[1327] on an appropriate change factor which should be used for inpatient hospital services for discharges in that fiscal year, together with its general recommendations under paragraph (2)(B) regarding the effectiveness and quality of health care delivery systems in the United States.[1328]

(B) The Secretary, not later than April 1, 1987, for fiscal year 1988 and not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1989), shall report to the Congress the Secretary's initial estimate of the percentage change that the Secretary will recommend under paragraph (4) with respect to that fiscal year.

(4)(A)[1329] Taking into consideration the recommendations of the Commission, the Secretary shall recommend for each fiscal year (beginning with fiscal year 1988) an appropriate change factor for inpatient hospital services for discharges in that fiscal year which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. The appropriate change factor may be different for all large urban subsection (d) hospitals, other urban subsection (d) hospitals, urban subsection (d) Puerto Rico hospitals, rural subsection (d) hospitals, and rural subsection (d) Puerto Rico hospitals, and all other hospitals and units not paid under subsection (d), and may vary among such other hospitals and units.[1330]

(B) In addition to the recommendation made under subparagraph (A), the Secretary shall, taking into consideration the recommendations of the Commission under paragraph (2)(B), recommend for each fiscal year (beginning with fiscal year 1992) other appropriate changes in each existing reimbursement policy under this title under which payments to an institution are based upon prospectively determined rates.[1331]

(5) The Secretary shall cause to have published in the Federal Register, not later than—

[1326] P.L. 101-508, §4002(g)(1)(B), added subparagraph (C), effective November 5, 1990.

[1327] P.L. 101-508, §4002(g)(2)(C)(i), struck out "the Secretary" and substituted "Congress", effective November 5, 1990.

[1328] P.L. 101-508, §4002(g)(2)(C)(ii), struck out a period and substituted ", together with its general recommendations under paragraph (2)(B) regarding the effectiveness and quality of health care delivery systems in the United States." effective November 5, 1990.

[1329] P.L. 101-508, §4002(g)(2)(D)(i), redesignated paragraph (4) as paragraph (4)(A), effective November 5, 1990.

[1330] See Vol. II, P.L. 99-509, §9321(c)(2), with respect to exclusion of capital-related regulations.

[1331] P.L. 101-508, §4002(g)(2)(D)(ii), added subparagraph (B), effective November 5, 1990.

(A) the May 1 before each fiscal year (beginning with fiscal year 1986), the Secretary's proposed recommendations[1332] under paragraph (4) for that fiscal year for public comment, and

(B) the September 1 before such fiscal year after such consideration of public comment on the proposal as is feasible in the time available, the Secretary's final recommendations[1333] under such paragraph for that year.

The Secretary shall include in the publication referred to in subparagraph (A) for a fiscal year the report of the Commission's recommendations submitted under paragraph (3) for that fiscal year. To the extent that the Secretary's recommendations under paragraph (4) differ from the Commission's recommendations for that fiscal year, the Secretary shall include in the publication referred to in subparagraph (A) an explanation of the Secretary's grounds for not following the Commission's recommendations.[1334]

(6)(A) The Commission shall consist of 17 individuals. Members of the Commission shall first be appointed no later than April 1, 1984, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than seven members expire in any one year.

(B) The membership of the Commission shall include individuals with national recognition for their expertise in health economics, hospital reimbursement, hospital financial management, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives, including physicians and registered professional nurses, employers, third party payors, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and individuals having expertise in the research and development of technological and scientific advances in health care.

(C) Subject to such review as the Office deems necessary to assure the efficient administration of the Commission, the Commission may—

(i) employ and fix the compensation of an Executive Director (subject to the approval of the Director of the Office) and such other personnel (not to exceed 25) as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(ii) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(iii) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(iv) make advance, progress, and other payments which relate to the work of the Commission;

(v) provide transportation and subsistence for persons serving without compensation; and

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[1332] P.L. 101-508, §4002(g)(2)(E)(i), struck out "recommendation" and substituted "recommendations", effective November 5, 1990.

[1333] P.L. 101-508, §4002(g)(2)(E)(i), struck out "recommendation" and substituted "recommendations", effective November 5, 1990.

[1334] P.L. 101-508, §4002(g)(2)(E)(ii), added this sentence, effective November 5, 1990.

(vi) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

Section 10(a)(1) of the Federal Advisory Committee Act[1335] shall not apply to any portion of a Commission meeting if the Commission, by majority vote, determines that such portion of such meeting should be closed.

(D) While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and his regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.[1336]

(E) In order to identify medically appropriate patterns of health resources use in accordance with paragraph (2), the Commission shall collect and assess information on medical and surgical procedures and services, including information on regional variations of medical practice and lengths of hospitalization and on other patient-care data, giving special attention to treatment patterns for conditions which appear to involve excessively costly or inappropriate services not adding to the quality of care provided. In order to assess the safety, efficacy, and cost-effectiveness of new and existing medical and surgical procedures, the Commission shall, in coordination to the extent possible with the Secretary, collect and assess factual information, giving special attention to the needs of updating existing diagnosis-related groups, establishing new diagnosis-related groups, and making recommendations on relative weighting factors for such groups to reflect appropriate differences in resource consumption in delivering safe, efficacious, and cost-effective care. In collecting and assessing information, the Commission shall—

(i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this paragraph;

(ii) carry out, or award grants or contracts for, original research and experimentation, including clinical research, where existing information is inadequate for the development of useful and valid guidelines by the Commission; and

(iii) adopt procedures allowing any interested party to submit information with respect to medical and surgical procedures and services (including new practices, such as the use of new technologies and treatment modalities), which information the Commission shall consider in making reports and recommendations to the Secretary and Congress.

[1335] P.L. 92-463.

[1336] See Vol. II, P.L. 100-647, §8405, with respect to election of personnel policy for ProPAC employees.

(F) The Commission shall have access to such relevant information and data as may be available from appropriate Federal agencies and shall assure that its activities, especially the conduct of original research and medical studies, are coordinated with the activities of Federal agencies.

(G)[(i) Stricken.[1337]]

(i)[1338] The Office shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon its request.

(ii)[1339] In order to carry out its duties under this paragraph, the Office is authorized to expend reasonable and neccessary[1340] funds as mutually agreed upon by the Office and the Commission. The Office shall be reimbursed for such funds by the Commission from the appropriations made with respect to the Commission.

(H) The Commission shall be subject to periodic audit by the General Accounting Office.

(I)(i) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this paragraph.

(ii) Eighty-five percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 15 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

(J) The Commission shall submit requests for appropriations in the same manner as the Office submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Office.

(f)(1)(A) The Secretary shall maintain a system for the reporting of costs of hospitals receiving payments computed under subsection (d).

(B)(i) Subject to clause (ii), the Secretary shall place into effect a standardized electronic cost reporting format for hospitals under this title.

(ii) The Secretary may delay or waive the implementation of such format in particular instances where such implementation would result in financial hardship (in particular with respect to hospitals with a small percentage of inpatients entitled to benefits under this title).[1341]

(2) If the Secretary determines, based upon information supplied by a utilization and quality control peer review organization under part B of title XI, that a hospital, in order to circumvent the payment method established under subsection (b) or (d) of this section, has taken an action that results in the admission of individuals entitled to benefits under part A unnecessarily, unnecessary multiple admissions of the same such individuals, or other inappropriate medical or other practices with respect to such individuals, the Secretary may—

[1337] P.L. 101-508, §4002(g)(2)(F)(i), struck out clause (i), effective November 5, 1990. [For clause (i) as it formerly read, see Vol. III, P.L. 101-508.]

[1338] P.L. 101-508, §4002(g)(2)(F)(ii), redesignated clause (ii) as clause (i), effective November 5, 1990.

[1339] P.L. 101-508, §4002(g)(2)(F)(ii), redesignated clause (iii) as clause (ii), effective November 5, 1990.

[1340] As in original; should be "necessary".

[1341] P.L. 100-203, §4007(b)(1)(C), as amended by P.L. 100-360, §411(b)(6)(B), added subparagraph (B), applicable to hospital cost reporting periods beginning on or after October 1, 1989.

(A) deny payment (in whole or in part) under part A with respect to inpatient hospital services provided with respect to such an unnecessary admission (or subsequent admission of the same individual), or

(B) require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(3) The provisions of subsections (c) through (g) of section 1128 shall apply to determinations made under paragraph (2) in the same manner as they apply to exclusions effected under section 1128(b)(13).

(g)(1)(A) Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary shall, for hospital cost reporting periods beginning on or after October 1, 1991, provide for payments for such costs in accordance with a prospective payment system established by the Secretary. Aggregate payments made under subsection (d) and this subsection during fiscal years 1992 through 1995 shall be reduced in a manner that results in a reduction (as estimated by the Secretary) in the amount of such payments equal to a 10 percent reduction in the amount of payments attributable to capital-related costs that would otherwise have been made during such fiscal year had the amount of such payments been based on reasonable costs (as defined in section 1861(v)).[1342]

(B) Such system—

(i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

(C) In this paragraph, the term "capital-related costs" has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.

(2)(A) The Secretary shall provide that the amount which is allowable, with respect to reasonable costs of inpatient hospital services for which payment may be made under this title, for a return on equity capital for hospitals shall, for cost reporting periods beginning on or after the date of the enactment of this subsection[1343], be equal to amounts otherwise allowable under regulations in effect on March 1, 1983, except that the rate of return to be recognized shall be equal to the applicable percentage (described in subparagraph (B)) of the average of the rates of interest, for each of the months any part of which is included in the reporting period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(B) In this paragraph, the "applicable percentage" is—

[1342] P.L. 101-508, §4001(b), added this sentence, effective November 5, 1990.

[1343] April 20, 1983, [P.L. 98-21; 97 Stat. 65].

(i) 75 percent, for cost reporting periods beginning during fiscal year 1987,

(ii) 50 percent, for cost reporting periods beginning during fiscal year 1988,

(iii) 25 percent, for cost reporting periods beginning during fiscal year 1989, and

(iv) 0 percent, for cost reporting periods beginning on or after October 1, 1989.[1344]

(3)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of inpatient hospital services of a subsection (d) hospital and a subsection (d) Puerto Rico hospital, the Secretary shall reduce the amounts of such payments otherwise established under this title by—

(i) 3.5 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1987,

(ii) 7 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1988 on or after October 1, 1987, and before January 1, 1988,

(iii) 12 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) in fiscal year 1988, occurring on or after January 1, 1988,[1345]

(iv) 15 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be)[1346] occurring during fiscal year 1989, and[1347]

(v) 15 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during the period beginning January 1, 1990, and ending September 30, 1991[1348]. [1349]

(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii)[1350] or a rural primary care hospital (as defined in section 1861(mm)(1)).[1351]

(h) PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—

(1) SUBSTITUTION OF SPECIAL PAYMENT RULES.—Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection. In providing for such payments,

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[1344] See Vol. II, P.L. 99-509, §9321(c)(3), with respect to regulations.

[1345] P.L. 101-239, §6002(1), struck out "and".

[1346] P.L. 101-234, §301(b)(3), struck out "may) be" and substituted "may be)", effective December 19, 1989.

P.L. 101-234, §301(c)(3), made the same amendment.

[1347] P.L. 101-239, §6002(2), struck out the period and substituted ", and".

See Vol. II, P.L. 99-509, §9321(c)(3), with respect to regulations.

[1348] P.L. 101-508, §4001(a), struck out "September 30, 1990" and substituted "September 30, 1991", effective November 5, 1990.

[1349] P.L. 101-239, §6002(3), added clause (v), effective December 19, 1989.

[1350] No final parenthesis.

[1351] P.L. 101-239, §6003(e)(2)(E), struck out "(d)(5)(C)(ii)" and substituted "(d)(5)(D)(iii)", effective December 19, 1989.

P.L. 101-508, §4001(c), struck out "subsection (d)(5)(D)(iii))." and substituted "subsection (d)(5)(D)(iii) or a rural primary care hospital (as defined in section 1861(mm)(1)).", effective November 5, 1990.

See Vol. II, P.L. 99-509, §9321(c)(3), with respect to regulations.

the Secretary shall provide for an allocation of such payments between part A and part B (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

(2) Determination of hospital-specific approved FTE resident amounts.—The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985, as follows:

(A) Determining allowable average cost per FTE resident in a hospital's base period.—The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this title for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

(B) Updating to the first cost reporting period.—

(i) In general.—The Secretary shall update each average amount determined under subparagraph (A) by the percentage increase in the consumer price index during the 12-month cost reporting period described in such subparagraph.

(ii) Exception.—The Secretary shall not perform an update under clause (i) in the case of a hospital if the hospital's reporting period, described in subparagraph (A), began on or after July 1, 1984, and before October 1, 1984.

(C) Amount for first cost reporting period.—For the first cost reporting period of the hospital beginning on or after July 1, 1985, the approved FTE resident amount for the hospital is equal to the amount determined under subparagraph (B) increased by 1 percent.

(D) Amount for subsequent cost reporting periods.—For each subsequent cost reporting period, the approved FTE resident amount for the hospital is equal to the amount determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous under- or over-estimations under this subparagraph in the projected percentage change in the consumer price index.

(E) Treatment of certain hospitals.—In the case of a hospital that did not have an approved medical residency training program or was not participating in the program under this title for a cost reporting period beginning during fiscal year 1984, the Secretary shall, for the first such period for which it has such a residency training program and is participating under this title, provide for such approved FTE resident amount as the Secretary determines to be appropriate, based on approved FTE resident amounts for comparable programs.

(3) Hospital payment amount per resident.—

(A) IN GENERAL.—The payment amount, for a hospital cost reporting period beginning on or after July 1, 1985, is equal to the product of—

(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

(ii) the hospital's medicare patient load (as defined in subparagraph (C)) for that period.

(B) AGGREGATE APPROVED AMOUNT.—As used in subparagraph (A), the term "aggregate approved amount" means, for a hospital cost reporting period, the product of—

(i) the hospital's approved FTE resident amount (determined under paragraph (2)) for that period, and

(ii) the weighted average number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital's approved medical residency training programs in that period.

(C) MEDICARE PATIENT LOAD.—As used in subparagraph (A), the term "medicare patient load" means, with respect to a hospital's cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be made under part A.

(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

(A) RULES.—The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.

(B) ADJUSTMENT FOR PART-YEAR OR PART-TIME RESIDENTS.—Such rules shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital.

(C) WEIGHTING FACTORS FOR CERTAIN RESIDENTS.—Subject to subparagraph (D), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved residency program—

(i) before July 1, 1986, for each resident the weighting factor is 1.00,

(ii) on or after July 1, 1986, for a resident who is in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is 1.00,

(iii) on or after July 1, 1986, and before July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .75, and

(iv) on or after July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .50.

(D) FOREIGN MEDICAL GRADUATES REQUIRED TO PASS FMGEMS EXAMINATION.—

(i) IN GENERAL.—Except as provided in clause (ii), such rules shall provide that, in the case of an individual who is a foreign medical graduate (as defined in paragraph (5)(D)), the individual shall not be counted as a resident on or after July 1, 1986, unless—

(I) the individual has passed the FMGEMS examination (as defined in paragraph (5)(E)), or

(II) the individual has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates.

(ii) TRANSITION FOR CURRENT FMGS.—On or after July 1, 1986, but before July 1, 1987, in the case of a foreign medical graduate who—

(I) has served as a resident before July 1, 1986, and is serving as a resident after that date, but

(II) has not passed the FMGEMS examination or a previous examination of the Educational Commission for Foreign Medical Graduates before July 1, 1986,

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

(E) COUNTING TIME SPENT IN OUTPATIENT SETTINGS.—Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

(5) DEFINITIONS AND SPECIAL RULES.—As used in this subsection:

(A) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—The term "approved medical residency training program" means a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary.

(B) CONSUMER PRICE INDEX.—The term "consumer price index" refers to the Consumer Price Index for All Urban Consumers (United States city average), as published by the Secretary of Commerce.

(C) DIRECT GRADUATE MEDICAL EDUCATION COSTS.—The term "direct graduate medical education costs" means direct costs of approved educational activities for approved medical residency training programs.

(D) FOREIGN MEDICAL GRADUATE.—The term "foreign medical graduate" means a resident who is not a graduate of—

(i) a school of medicine accredited by the Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges (or approved by such Committee as meeting the standards necessary for such accreditation),

(ii) a school of osteopathy accredited by the American Osteopathic Association, or approved by such Association as meeting the standards necessary for such accreditation, or

(iii) a school of dentistry or podiatry which is accredited (or meets the standards for accreditation) by an organization recognized by the Secretary for such purpose.

(E) FMGEMS EXAMINATION.—The term "FMGEMS examination" means parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences recognized by the Secretary for this purpose.

(F) INITIAL RESIDENCY PERIOD.—The term "initial residency period" means the period of board eligibility plus one year, except that—

(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of formal training of more than five years for any individual, and

(ii) a period, of not more than two years, during which an individual is in a geriatric residency or fellowship program which meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period.

The initial residency period shall be determined, with respect to a resident, as of the time the resident enters the residency training program.

(G) PERIOD OF BOARD ELIGIBILITY.—

(i) GENERAL RULE.—Subject to clauses (ii) and (iii), the term "period of board eligibility" means, for a resident, the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training.

(ii) APPLICATION OF 1985-1986 DIRECTORY.—Except as provided in clause (iii), the period of board eligibility shall be such period specified in the 1985-1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education.

(iii) CHANGES IN PERIOD OF BOARD ELIGIBILITY.—On or after July 1, 1989, if the Accreditation Council on Graduate Medical Education, in its Directory of Residency Training Programs—

(I) increases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, above the period specified in its 1985-1986 Directory, the Secretary may increase the period of board eligibility for that specialty, but not to exceed the period of board eligibility specified in that later Directory, or

(II) decreases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, below the period specified in its 1985-1986 Directory, the Secretary may decrease the period of board eligibility for that specialty, but not below the period of board eligibility specified in that later Directory.

(H) RESIDENT.—The term "resident" includes an intern or other participant in an approved medical residency training program.

(i) AVOIDING DUPLICATIVE PAYMENTS TO HOSPITALS PARTICIPATING IN RURAL DEMONSTRATION PROGRAMS.—The Secretary shall reduce any payment amounts otherwise determined under this section to the extent necessary to avoid duplication of any payment made under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987[1352]. [1353]

PAYMENT OF PROVIDER-BASED PHYSICIANS AND PAYMENT UNDER CERTAIN PERCENTAGE ARRANGEMENTS

SEC. 1887. [42 U.S.C. 1395xx] (a)(1) The Secretary shall by regulation determine criteria for distinguishing those services (including inpatient and outpatient services) rendered in hospitals or skilled nursing facilities—

(A) which constitute professional medical services, which are personally rendered for an individual patient by a physician and which contribute to the diagnosis or treatment of an individual patient, and which may be reimbursed as physicians' services under part B, and

(B) which constitute professional services which are rendered for the general benefit to patients in a hospital or skilled nursing facility and which may be reimbursed only on a reasonable cost basis or on the bases described in section 1886.

(2)(A) For purposes of cost reimbursement, the Secretary shall recognize as a reasonable cost of a hospital or skilled nursing facility only that portion of the costs attributable to services rendered by a physician in such hospital or facility which are services described in paragraph (1)(B), apportioned on the basis of the amount of time actually spent by such physician rendering such services.

(B) In determining the amount of the payments which may be made with respect to services described in paragraph (1)(B), after apportioning costs as required by subparagraph (A), the Secretary may not recognize as reasonable (in the efficient delivery of health services) such portion of the provider's costs for such services to the extent that such costs exceed the reasonable compensation equivalent for such services. The reasonable compensation equivalent for any service shall be established by the Secretary in regulations.

(C) The Secretary may, upon a showing by a hospital or facility that it is unable to recruit or maintain an adequate number of physicians for the hospital or facility on account of the reimbursement limits established under this subsection, grant exceptions to such reimbursement limits as may be necessary to allow such provider to provide a compensation level sufficient to provide adequate physician services in such hospital or facility.

(b)(1) Except as provided in paragraph (2), in the case of a provider of services which is paid under this title on a reasonable cost basis, or other basis related to costs that are reasonable, and which has entered into a contract for the purpose of having services furnished for or on behalf of it, the Secretary may not include any cost incurred by the provider under the contract if the amount payable under the contract by the provider for that cost is determined on the basis of a percentage (or other proportion) of the provider's charges, revenues, or claim for reimbursement.

[1352] P.L. 100-203.

[1353] P.L. 101-239, §6003(g)(4), added subsection (i), effective December 19, 1989.

(2) Paragraph (1) shall not apply—

(A) to services furnished by a physician and described in subsection (a)(1)(B) and covered by regulations in effect under subsection (a), and

(B) under regulations established by the Secretary, where the amount involved under the percentage contract is reasonable and the contract—

(i) is a customary commercial business practice, or

(ii) provides incentives for the efficient and economical operation of the provider of services.

PAYMENT TO SKILLED NURSING FACILITIES FOR ROUTINE SERVICE COSTS

SEC. 1888. [42 U.S.C. 1395yy] (a) The Secretary, in determining the amount of the payments which may be made under this title with respect to routine service costs of extended care services shall not recognize as reasonable (in the efficient delivery of health services) per diem costs of such services to the extent that such per diem costs exceed the following per diem limits, except as otherwise provided in this section:

(1) With respect to freestanding skilled nursing facilities located in urban areas, the limit shall be equal to 112 percent of the mean per diem routine service costs for freestanding skilled nursing facilities located in urban areas.

(2) With respect to freestanding skilled nursing facilities located in rural areas, the limit shall be equal to 112 percent of the mean per diem routine service costs for freestanding skilled nursing facilities located in rural areas.

(3) With respect to hospital-based skilled nursing facilities located in urban areas, the limit shall be equal to the sum of the limit for freestanding skilled nursing facilities located in urban areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based skilled nursing facilities located in urban areas exceeds the limit for freestanding skilled nursing facilities located in urban areas.

(4) With respect to hospital-based skilled nursing facilities located in rural areas, the limit shall be equal to the sum of the limit for freestanding skilled nursing facilities located in rural areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based skilled nursing facilities located in rural areas exceeds the limit for freestanding skilled nursing facilities located in rural areas.

In applying this subsection the Secretary shall make appropriate adjustments to the labor related portion of the costs based upon an appropriate wage index, and shall, for cost reporting periods beginning on or after October 1, 1992 and every 2 years thereafter, provide for an update to the per diem cost limits described in this subsection[1354]

[1354] P.L. 101-508, §4008(e)(2), struck out a period and added ", and shall, for cost reporting periods beginning on or after October 1, 1992 and every 2 years thereafter, provide for an update to the per diem cost limits described in this subsection", effective as if included in the enactment of P.L. 101-

(b) With respect to a hospital-based skilled nursing facility, the Secretary shall recognize as reasonable the portion of the cost differences between hospital-based and freestanding skilled nursing facilities attributable to excess overhead allocations (as determined by the Secretary) resulting from the reimbursement principles under this title, notwithstanding the limits set forth in paragraph (3) or (4) of subsection (a).

(c) The Secretary may make adjustments in the limits set forth in subsection (a) with respect to any skilled nursing facility to the extent the Secretary deems appropriate, based upon case mix or circumstances beyond the control of the facility. The Secretary shall publish the data and criteria to be used for purposes of this subsection on an annual basis.

(d)(1) Any skilled nursing facility may choose to be paid under this subsection on the basis of a prospective payment for all routine service costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title) and capital-related costs[1355] of extended care services provided in a cost reporting period if such facility had, in the preceding cost reporting period, fewer than 1,500 patient days with respect to which payments were made under this title. Such prospective payment shall be in lieu of payments which would otherwise be made for routine service costs pursuant to section 1861(v) and subsections (a) through (c) of this section and capital-related costs pursuant to section 1861(v). This subsection shall not apply to a facility for any cost reporting period immediately following a cost reporting period in which such facility had 1,500 or more patient days with respect to which payments were made under this title, without regard to whether payments were made under this subsection during such preceding cost reporting period.

(2)(A) The amount of the payment under this section shall be determined on a per diem basis.

(B) Subject to the limitations of subparagraph (C), for skilled nursing facilities located—

(i) in an urban area, the amount shall be equal to 105 percent of the mean of the per diem reasonable routine service and capital-related costs of extended care services for skilled nursing facilities in urban areas within the same region, determined without regard to the limitations of subsection (a) and adjusted for different area wage levels, and

(ii) in a rural area the amount shall be equal to 105 percent of the mean of the per diem reasonable routine service and capital-related costs of extended care services for skilled nursing facilities in rural areas within the same region, determined without regard to the limitations of subsection (a) and adjusted for different area wage levels.

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239. As in original. No final punctuation.

See Vol. II, P.L. 101-239, §6024, with respect to use of more recent data regarding routine service costs of skilled nursing facilities and §6026, with respect to a GAO study of hospital-based and freestanding skilled nursing facilities.

[1355] P.L. 101-508, §4008(h)(2)(A)(ii), struck out "(and capital-related costs)" and substituted "(including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title) and capital-related costs", effective as if included in the enactment of P.L. 101-239.

(C) The per diem amounts determined under subparagraph (B) shall not exceed the limit on routine service costs determined under subsection (a) with respect to the facility, adjusted to take into account average capital-related costs with respect to the type and location of the facility.

(3) For purposes of this subsection, urban and rural areas shall be determined in the same manner as for purposes of subsection (a), and the term "region" shall have the same meaning as under section 1886(d)(2)(D).

(4) The Secretary shall establish the prospective payment amounts for cost reporting periods beginning in a fiscal year at least 90 days prior to the beginning of such fiscal year, on the basis of the most recent data available for a 12-month period. A skilled nursing facility must notify the Secretary of its intention to be paid pursuant to this subsection for a cost reporting period no later than 30 days before the beginning of that period.

(5) The Secretary shall provide for a simplified cost report to be filed by facilities being paid pursuant to this subsection, which shall require only the cost information necessary for determining prospective payment amounts pursuant to paragraph (2) and reasonable costs of ancillary services.

(6) In lieu of payment on a cost basis for ancillary services provided by a facility which is being paid pursuant to this subsection, the Secretary may pay for such ancillary services on a reasonable charge basis if the Secretary determines that such payment basis will provide an equitable level of reimbursement and will ease the reporting burden of the facility.

(7) In computing the rates of payment to be made under this subsection, there shall be taken into account the costs described in the last sentence of section 1861(v)(1)(E) (relating to compliance with nursing facility requirements and of conducting nurse aide training and competency evaluation programs and competency evaluation programs).[1356]

MEDICARE AND MEDIGAP INFORMATION BY TELEPHONE[1357]

SEC. 1889. [42 U.S.C. 1395zz] The Secretary shall provide information via a toll-free telephone number on the programs under this title and on medicare supplemental policies as defined in section 1882(g)(1) (including the relationship of State programs under title XIX to such policies).

[SEC. 1890.[1358]]

CONDITIONS OF PARTICIPATION FOR HOME HEALTH AGENCIES; HOME HEALTH QUALITY[1359]

[1356] P.L. 100-203, §4201(b)(2), added paragraph (7). For the effective date, see Vol. II, P.L. 100-203, §4204(a).

[1357] P.L. 100-203, §4062 [as amended by P.L. 101-508, §4152(h)], repealed §1889, applicable to covered items (other than oxygen and oxygen equipment) furnished on or after January 1, 1989, and to oxygen and oxygen equipment furnished on or after June 1, 1989. [For §1889 as it formerly read, see Vol. III, P.L. 100-203.]

P.L. 101-508, §4361(a), added a new §1889, effective November 5, 1990.

See Vol. II, P.L. 101-508, §4361(b), with respect to demonstration projects.

[1358] P.L. 100-360, §411(i)(4)(D)(ii)(II) and (V), redesignated §1890 as §1862(e)(2), and transferred such paragraph accordingly.

[1359] P.L. 100-203, §4021(b), added §1891, applicable to home health agencies as of June 1, 1989, except as otherwise provided.

SEC. 1891. [42 U.S.C. 1395bbb] (a) The conditions of participation that a home health agency is required to meet under this subsection are as follows:

(1) The agency protects and promotes the rights of each individual under its care, including each of the following rights:

(A) The right to be fully informed in advance about the care and treatment to be provided by the agency, to be fully informed in advance of any changes in the care or treatment to be provided by the agency that may affect the individual's well-being, and (except with respect to an individual adjudged incompetent) to participate in planning care and treatment or changes in care or treatment.

(B) The right to voice grievances with respect to treatment or care that is (or fails to be) furnished without discrimination or reprisal for voicing grievances.

(C) The right to confidentiality of the clinical records described in section 1861(o)(3).

(D) The right to have one's property treated with respect.

(E) The right to be fully informed orally and in writing (in advance of coming under the care of the agency) of—

(i) all items and services furnished by (or under arrangements with) the agency for which payment may be made under this title,

(ii) the coverage available for such items and services under this title, title XIX, and any other Federal program of which the agency is reasonably aware,

(iii) any charges for items and services not covered under this title and any charges the individual may have to pay with respect to items and services furnished by (or under arrangements with) the agency, and

(iv) any changes in the charges or items and services described in clause (i), (ii), or (iii).

(F) The right to be fully informed in writing (in advance of coming under the care of the agency) of the individual's rights and obligations under this title.

(G) The right to be informed of the availability of the State home health agency hot-line established under section 1864(a).

(2) The agency notifies the State entity responsible for the licensing or certification of the agency of a change in—

(A) the persons with an ownership or control interest (as defined in section 1124(a)(3)) in the agency,

(B) the persons who are officers, directors, agents, or managing employees (as defined in section 1126(b)) of the agency, and

(C) the corporation, association, or other company responsible for the management of the agency.

Such notice shall be given at the time of the change and shall include the identity of each new person or company described in the previous sentence.

(3)(A) The agency must not use as a home health aide (on a full-time, temporary, per diem, or other basis), any individual[1360] to provide items or services described in section 1861(m) on or after January 1, 1990, unless the individual—

[1360] P.L. 100-360, §411(d)(1)(A)(i), struck out "who is not a licensed health care professional (as defined in subparagraph (F))", effective as if included in the enactment of P.L. 100-203.

(i) has completed a training and competency evaluation program, or a competency evaluation program, that meets the minimum standards established by the Secretary under subparagraph (D), and

(ii) is competent to provide such items and services.

For purposes of clause (i), an individual is not considered to have completed a training and competency evaluation program, or a competency evaluation program if, since the individual's most recent completion of such a program, there has been a continuous period of 24 consecutive months during none of which the individual provided items and services described in section 1861(m) for compensation.

(B)(i) The agency must provide, with respect to individuals used as a home health aide by the agency as of July 1, 1989, for a competency evaluation program (as described in subparagraph (A)(i)) and such preparation as may be necessary for the individual to complete such a program by January 1, 1990.

(ii) The agency must provide such regular performance review and regular in-service education as assures that individuals used to provide items and services described in section 1861(m) are competent to provide those items and services.

(C) The agency must not permit an individual, other than in a training and competency evaluation program that meets the minimum standards established by the Secretary under subparagraph (D), to provide items or services of a type for which the individual has not demonstrated competency.

(D)(i) The Secretary shall establish minimum standards for the programs described in subparagraph (A) by not later than October 1, 1988.

(ii) Such standards shall include the content of the curriculum, minimum hours of training, qualification of instructors, and procedures for determination of competency.

(iii) Such standards may permit approval of programs offered by or in home health agencies, as well as outside agencies (including employee organizations), and of programs in effect on the date of the enactment of this section[1361]; except that they may not provide for the approval of a program offered by or in a home health agency which, within the previous 2 years—

(I) has been determined to be out of compliance with subparagraph (A), (B), or (C);

(II) has been subject to an extended (or partial extended) survey under subsection (c)(2)(D);

(III) has been assessed a civil money penalty described in subsection (f)(2)(A)(i) of not less than $5,000; or

(IV) has been subject to the remedies described in subsection (e)(1) or in clauses (ii) or (iii) of subsection (f)(2)(A).[1362]

(iv) Such standards shall permit a determination that an individual who has completed (before July 1, 1989) a training and competency evaluation program or a competency evaluation program shall be deemed for purposes of subparagraph (A) to have completed a program that is approved by the Secretary under the standards established under this subparagraph if the Secretary determines that, at the time the program was offered, the program met such standards.

[1361] December 22, 1987 [P.L. 100-203; 101 Stat. 1330].

[1362] P.L. 101-508, §4027(sic)(i)(1), struck out "which has been *determined to be out of compliance* with the requirements specified in or pursuant to section 1861(o) or subsection (a) within the previous 2 years." and substituted "which, within the previous 2 years—" and subclauses (I)-(IV). For the effective date, see Vol. II, P.L. 101-508, §4027(sic)(i)(2).

(E) In this paragraph, the term "home health aide" means any individual who provides the items and services described in section 1861(m), but does not include an individual—

(i) who is a licensed health professional (as defined in subparagraph (F)), or

(ii) who volunteers to provide such services without monetary compensation.

(F) In this paragraph, the term "licensed health professional" means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant,[1363] registered professional nurse, licensed practical nurse, or licensed or certified social worker.

(4)[1364] The agency includes an individual's plan of care required under section 1861(m) as part of the clinical records described in section 1861(o)(3).

(5)[1365] The agency operates and provides services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1124) and with accepted professional standards and principles which apply to professionals providing items and services in such an agency.

(6) The agency complies with the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).[1366]

(b) It is the duty and responsibility of the Secretary to assure that the conditions of participation and requirements specified in or pursuant to section 1861(o) and subsection (a) of this section and the enforcement of such conditions and requirements are adequate to protect the health and safety of individuals under the care of a home health agency and to promote the effective and efficient use of public moneys.

(c)(1) Any agreement entered into or renewed by the Secretary pursuant to section 1864 relating to home health agencies shall provide that the appropriate State or local agency shall conduct, without any prior notice, a standard survey of each home health agency. Any individual who notifies (or causes to be notified) a home health agency of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A.[1367] The Secretary shall review each State's or local agency's procedures for scheduling and conduct of standard surveys to assure that the State or agency has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

[1363] P.L. 100-360, §411(d)(1)(A)(ii), inserted "physical or occupational therapy assistant,", effective as if included in the enactment of P.L. 100-203.

[1364] P.L. 100-360, §411(d)(1)(A)(iii), struck out the former paragraph (4) and redesignated paragraph (5) as paragraph (4), effective as if included in the enactment of P.L. 100-203. [For paragraph (4) as it formerly read, see Vol. III, P.L. 100-360.]

[1365] P.L. 100-360, §411(d)(1)(A)(iii), redesignated paragraph (6) as paragraph (5), effective as if included in the enactment of P.L. 100-203.

[1366] P.L. 101-508, §4206(d)(2), added paragraph (6), applicable to services furnished on or after December 1, 1991.

(2)(A) Except as provided in subparagraph (B), each home health agency shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this paragraph. The statewide average interval between standard surveys of any home health agency shall not exceed 12 months.

(B) If not otherwise conducted under subparagraph (A), a standard survey (or an abbreviated standard survey) of an agency—

(i) may be conducted within 2 months of any change of ownership, administration, or management of the agency to determine whether the change has resulted in any decline in the quality of care furnished by the agency, and

(ii) shall be conducted within 2 months of when a significant number of complaints have been reported with respect to the agency to the Secretary, the State, the entity responsible for the licensing of the agency, the State or local agency responsible for maintaining a toll-free hotline and investigative unit (under section 1864(a)), or any other appropriate Federal, State, or local agency.

(C) A standard survey conducted under this paragraph with respect to a home health agency—

(i) shall include (to the extent practicable), for a case-mix stratified sample of individuals furnished items or services by the agency—

(I) visits to the homes of such individuals, but only with the consent of such individuals, for the purpose of evaluating (in accordance with a standardized reproducible assessment instrument (or instruments) approved by the Secretary under subsection (d)) the extent to which the quality and scope of items and services furnished by the agency attained and maintained the highest practicable functional capacity of each such individual as reflected in such individual's written plan of care required under section 1861(m) and clinical records required under section 1861(o)(3); and

(II) a survey of the quality of care and services furnished by the agency as measured by indicators of medical, nursing, and rehabilitative care;

(ii) shall be based upon a protocol that is developed, tested, and validated by the Secretary not later than January 1, 1989; and

(iii) shall be conducted by an individual—

(I) who meets minimum qualifications established by the Secretary not later than July 1, 1989,

(II) who is not serving (or has not served within the previous 2 years) as a member of the staff of, or as a consultant to, the home health agency surveyed respecting compliance with the conditions of participation specified in or pursuant to section 1861(o) or subsection (a) of this section, and

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[1367] P.L. 100-360, §411(d)(2)(A) [as amended by P.L. 100-485, §608(d)(20)(A)], amended this sentence in its entirety, effective as if included in the enactment of P.L. 100-203. Until then, this sentence reads as follows: "The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1128A.".

(III) who has no personal or familial financial interest in the home health agency surveyed.

(D) Each home health agency that is found, under a standard survey, to have provided substandard care shall be subject to an extended survey to review and identify the policies and procedures which produced such substandard care and to determine whether the agency has complied with the conditions of participation specified in or pursuant to section 1861(o) or subsection (a) of this section. Any other agency may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey). The extended survey shall be conducted immediately after the standard survey (or, if not practical, not later than 2 weeks after the date of completion of the standard survey).

(E) Nothing in this paragraph shall be construed as requiring an extended (or partial extended) survey as a prerequisite to imposing a sanction against an agency under subsection (e) on the basis of the findings of a standard survey.[1368]

(d)(1) Not later than January 1, 1989, the Secretary shall designate an assessment instrument (or instruments) for use by an agency in complying with subsection (c)(2)(C)(I)[1369].

(2)(A) Not later than January 1, 1992[1370], the Secretary shall—

(i) evaluate the assessment process,

(ii) report to Congress on the results of such evaluation, and

(iii) based on such evaluation, make such modifications in the assessment process as the Secretary determines are appropriate.

(B) The Secretary shall periodically update the evaluation conducted under subparagraph (A), report the results of such update to Congress, and, based on such update, make such modifications in the assessment process as the Secretary determines are appropriate.

(3) The Secretary shall provide for the comprehensive training of State and Federal surveyors in matters relating to the performance of standard and extended surveys under this section, including the use of any assessment instrument (or instruments) designated under paragraph (1).[1371]

(e)(1) If the Secretary determines on the basis of a standard, extended, or partial extended survey or otherwise, that a home health agency that is certified for participation under this title is no longer in compliance with the requirements specified in or pursuant to section 1861(o) or subsection (a) and determines that the deficiencies involved immediately jeopardize the health and safety of the individuals to whom the agency furnishes items and services, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subsection (f)(2)(A)(iii) or terminate the certification of the agency, and may provide, in addition, for 1 or more of the other remedies described in subsection (f)(2)(A).

[1368] P.L. 100-203, §4022(a), added subsection (c), effective on June 1, 1989, unless otherwise specifically provided in §1891(d).

[1369] As in original. Probably should be "(c)(2)(C)(i)(I)".

[1370] P.L. 100-360, §411(d)(2)(B), struck out "1991" and substituted "1992", effective as if included in the enactment of P.L. 100-203.

[1371] P.L. 100-203, §4022(a), added subsection (d), effective on June 1, 1989, unless otherwise specifically provided in §1891(d).

(2) If the Secretary determines on the basis of a standard, extended, or partial extended survey or otherwise, that a home health agency that is certified for participation under this title is no longer in compliance with the requirements specified in or pursuant to section 1861(o) or subsection (a) and determines that the deficiencies involved do not immediately jeopardize the health and safety of the individuals to whom the agency furnishes items and services, the Secretary may (for a period not to exceed 6 months) impose intermediate sanctions developed pursuant to subsection (f), in lieu of terminating the certification of the agency. If, after such a period of intermediate sanctions, the agency is still no longer in compliance with the requirements specified in or pursuant to section 1861(o) or subsection (a), the Secretary shall terminate the certification of the agency.

(3) If the Secretary determines that a home health agency that is certified for participation under this title is in compliance with the requirements specified in or pursuant to section 1861(o) or subsection (a) but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subsection (f)(2)(A)(i) for the days in which it finds that the agency was not in compliance with such requirements.

(4) The Secretary may continue payments under this title with respect to a home health agency not in compliance with the requirements specified in or pursuant to section 1861(o) or subsection (a) over a period of not longer than 6 months, if—

(A) the State or local survey agency finds that it is more appropriate to take alternative action to assure compliance of the agency with the requirements than to terminate the certification of the agency,

(B) the agency has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(C) the agency agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by home health agencies under this subparagraph.[1372]

(f)(1) The Secretary shall develop and implement, by not later than April 1, 1989—

(A) a range of intermediate sanctions to apply to home health agencies under the conditions described in subsection (e), and

(B) appropriate procedures for appealing determinations relating to the imposition of such sanctions.

(2)(A) The intermediate sanctions developed under paragraph (1) shall include—

[1372] P.L. 100-203, §4023, added subsection (e), effective on June 1, 1989, except as otherwise specifically provided in §1891(e) or (f), and no intermediate sanction described in section 1891(f)(2)(A) shall be imposed for violations occurring before such effective date*.

P.L. 100-360, §411(d)(3)(A), redesignated P.L. 100-203, §4023, as §4023(a), effective as if included in the enactment of P.L. 100-203, §4023.

*P.L. 100-360, §411(d)(3)(C), amended P.L. 100-203, §4023(b), by adding ", and no intermediate sanction described in section 1891(f)(2)(A) of such Act shall be imposed for violations occurring before such effective date".

(i) civil money penalties in an amount not to exceed $10,000[1373] for each day of noncompliance,[1374]

(ii) suspension of all or part of the payments to which a home health agency would otherwise be entitled under this title with respect to items and services furnished by a home health agency on or after the date on which the Secretary determines that intermediate sanctions should be imposed pursuant to subsection (e)(2), and[1375]

(iii) the appointment of temporary management to oversee the operation of the home health agency and to protect and assure the health and safety of the individuals under the care of the agency while improvements are made in order to bring the agency into compliance with all the requirements specified in or pursuant to section 1861(o) or subsection (a).[1376]

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).[1377] The temporary management under clause (iii) shall not be terminated until the Secretary has determined that the agency has the management capability to ensure continued compliance with all the requirements referred to in that clause.[1378]

(B) The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law and shall not be construed as limiting other remedies, including any remedy available to an individual at common law.

(C) A finding to suspend payment under subparagraph (A)(ii) shall terminate when the Secretary finds that the home health agency is in substantial compliance with all the requirements specified in or pursuant to section 1861(o) and subsection (a).

(3) The Secretary shall develop and implement, by not later than April 1, 1989, specific procedures with respect to the conditions under which each of the intermediate sanctions developed under paragraph (1) is to be applied, including the amount of any fines and the severity of each of these sanctions. Such procedures shall be designed so as to minimize the time between identification of deficiencies and imposition of these sanctions and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.[1379]

[1373] P.L. 100-360, §411(d)(3)(B)(ii), inserted "in an amount not to exceed $10,000", effective as if included in the enactment of P.L. 100-203.

[1374] P.L. 100-360, §411(d)(3)(B)(i), moved the indentation of this clause 2 ems to the left, effective as if included in the enactment of P.L. 100-203.

[1375] P.L. 100-360, §411(d)(3)(B)(i), moved the indentation of this clause 2 ems to the left, effective as if included in the enactment of P.L. 100-203.

[1376] P.L. 100-360, §411(d)(3)(B)(i), moved the indentation of this clause 2 ems to the left, effective as if included in the enactment of P.L. 100-203.

[1377] P.L. 100-360, §411(d)(3)(B)(iii), added this sentence "after and below clause (iii)", effective as if included in the enactment of P.L. 100-203.

[1378] P.L. 100-360, §411(d)(3)(B)(i), moved the indentation of this sentence 2 ems to the left, effective as if included in the enactment of P.L. 100-203.

[1379] P.L. 100-203, §4023(a) [as redesignated by P.L. 100-360, §411(d)(3)(A)], added subsection (f), effective on June 1, 1989, except as otherwise specifically provided in §1891(e) or (f), and no intermediate sanction described in section 1891(f)(2)(A) shall be imposed for violations occurring before such effective date[*].

[*] P.L. 100-360, §411(d)(3)(C), amended this effective date by adding ", and no intermediate sanction described in section 1891(f)(2)(A) of such Act shall be imposed for violations occurring before such effective date".

OFFSET OF PAYMENTS TO INDIVIDUALS TO COLLECT PAST-DUE OBLIGATIONS ARISING FROM BREACH OF SCHOLARSHIP AND LOAN CONTRACT[1380]

SEC. 1892. [42 U.S.C. 1395ccc] (a) IN GENERAL.—

(1)(A) Subject to subparagraph (B), the Secretary shall enter into an agreement under this section with any individual who, by reason of a breach of a contract entered into by such individual pursuant to the National Health Service Corps Scholarship Program, the Physician Shortage Area Scholarship Program, or the Health Education Assistance Loan Program, owes a past-due obligation to the United States (as defined in subsection (b)).

(B) The Secretary shall not enter into an agreement with an individual under this section to the extent—

(i)(I) the individual has entered into a contract with the Secretary pursuant to section 204(a)(1) of the Public Health Service Amendments of 1987[1381], and

(II) the individual has fulfilled or (as determined by the Secretary) is fulfilling the terms of such contract; or

(ii) the liability of the individual under such section 204(a)(1) has otherwise been relieved under such section; or

(iii) the individual is performing such physician's service obligation under a forbearance agreement entered into with the Secretary under subpart II of part D of title III of the Public Health Service Act[1382].

(2) The agreement under this section shall provide that—

(A) deductions shall be made from the amounts otherwise payable to the individual under this title, in accordance with a formula and schedule agreed to by the Secretary and the individual, until such past-due obligation (and accrued interest) have been repaid;

(B) payment under this title for services provided by such individual shall be made only on an assignment-related basis;

(C) if the individual does not provide services, for which payment would otherwise be made under this title, of a sufficient quantity to maintain the offset collection according to the agreed upon formula and schedule—

(i) the Secretary shall immediately inform the Attorney General, and the Attorney General shall immediately commence an action to recover the full amount of the past-due obligation, and

(ii) subject to paragraph (4), the Secretary shall immediately exclude the individual from the program under this title, until such time as the entire past-due obligation has been repaid.

(3) If the individual refuses to enter into an agreement or breaches any provision of the agreement—

(A) the Secretary shall immediately inform the Attorney General, and the Attorney General shall immediately commence an action to recover the full amount of the past-due obligation, and

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[1380] See Vol. II, P.L. 94-437, §108(l)(1) and (2), with respect to the Indian Health Service loan repayment program.

[1381] P.L. 100-177.

[1382] P.L. 78-410.

(B) subject to paragraph (4), the Secretary shall immediately exclude the individual from the program under this title, until such time as the entire past-due obligation has been repaid.

(4) The Secretary shall not exclude an individual pursuant to paragraph (2)(C)(ii) or paragraph (3)(B) if such individual is a sole community practitioner or sole source of essential specialized services in a community if a State requests that the individual not be excluded.

(b) PAST-DUE OBLIGATION.—For purposes of this section, a past-due obligation is any amount—

(1) owed by an individual to the United States by reason of a breach of a scholarship contract under section 338E of the Public Health Service Act[1383] or under subpart III of part F of title VII of such Act (as in effect before October 1, 1976) and which has not been paid by the deadline established by the Secretary pursuant to such respective section, and has not been canceled, waived, or suspended by the Secretary pursuant to such section; or

(2) owed by an individual to the United States by reason of a loan covered by Federal loan insurance under subpart I of part C of title VII of the Public Health Service Act and payment for which has not been cancelled, waived, or suspended by the Secretary under such subpart.

(c) COLLECTION UNDER THIS SECTION SHALL NOT BE EXCLUSIVE.—This section shall not preclude the United States from applying other provisions of law otherwise applicable to the collection of obligations owed to the United States, including (but not limited to) the use of tax refund offsets pursuant to section 3720A of title 31, United States Code, and the application of other procedures provided under chapter 37 of title 31, United States Code.

(d) COLLECTION FROM PROVIDERS AND HEALTH MAINTENANCE ORGANIZATIONS.—

(1) In the case of an individual who owes a past-due obligation, and who is an employee of, or affiliated by a medical services agreement with, a provider having an agreement under section 1866 or a health maintenance organization or competitive medical plan having a contract under section 1833 or section 1876, the Secretary shall deduct the amounts of such past-due obligation from amounts otherwise payable under this title to such provider, organization, or plan.

(2) Deductions shall be in accordance with a formula and schedule agreed to by the Secretary, the individual and the provider, organization, or plan. The deductions shall be made from the amounts otherwise payable to the individual under this title as long as the individual continues to be employed or affiliated by a medical services agreement.

(3) Such deduction shall not be made until 6 months after the Secretary notifies the provider, organization, or plan of the amount to be deducted and the particular physicians to whom the deductions are attributable.

[1383] P.L. 78-410.

(4) A deduction made under this subsection shall relieve the individual of the obligation (to the extent of the amount collected) to the United States, but the provider, organization, or plan shall have a right of action to collect from such individual the amount deducted pursuant to this subsection (including accumulated interest).

(5) No deduction shall be made under this subsection if, within the 6-month period after notice is given to the provider, organization, or plan, the individual pays the past-due obligation, or ceases to be employed by the provider, organization, or plan.

(6) The Secretary shall also apply the provisions of this subsection in the case of an individual who is a member of a group practice, if such group practice submits bills under this program as a group, rather than by individual physicians.

(e) TRANSFER FROM TRUST FUNDS.—Amounts equal to the amounts deducted pursuant to this section shall be transferred from the Trust Fund from which the payment to the individual, provider, or other entity would otherwise have been made, to the general fund in the Treasury, and shall be credited as payment of the past-due obligation of the individual from whom (or with respect to whom) the deduction was made.

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS[1]

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[1] Title XIX of the Social Security Act is administered by the Health Care Financing Administration, Department of Health and Human Services (formerly the Department of Health, Education, and Welfare).

Title XIX appears in the United States Code as §§1396-1396u, subchapter XIX, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services relating to Title XIX are contained in chapter IV, Title 42, and subtitle A, Title 45, Code of Federal Regulations.

See Vol. II, 31 U.S.C. 6504-6505 with respect to intergovernmental cooperation.

See Vol. II, 31 U.S.C. 7501-7507 with respect to uniform audit requirements for State and local governments receiving Federal financial assistance.

See Vol. II, P.L. 78-410, §304(d)(4), with respect to study of cost of diseases and other adverse effects which are environmentally related; §317A(a) and (d), with respect to coordination required in lead poisoning prevention; §353(i)(3) and (n), with respect to clinical laboratories; and §1301(c)(3), with respect to the requirement that health maintenance organizations enroll individuals entitled to medical assistance under Title XIX.

See Vol. II, P.L. 79-396, §17(p), with respect to proprietary title XIX center.

See Vol. II, P.L. 88-164, §124(b)(3), with respect to the membership of the State Planning Councils.

See Vol. II, P.L. 88-352, §601, for prohibition against discrimination in federally assisted programs.

See Vol. II, P.L. 89-73, §§203 and 422(c), with respect to consultation, and §306(c) with respect to agreements with other agencies.

See Vol. II, P.L. 94-566, §503, with respect to preservation of medicaid eligibility for individuals who cease to be eligible for supplemental security income benefits on account of cost-of-living increases in social security benefits.

See Vol. II, P.L. 95-521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 97-300, §106(e)(2), with respect to performance standards; §172(a), with respect to assistance under this title; §202(b)(3)(B), with respect to governors' incentive grants; and §§501-505, with respect to the payment of a bonus for the successful job placement of certain employable dependent individuals.

See Vol. II, P.L. 98-369, §2320, with respect to payment for costs of certain New Jersey hospital-based mobile intensive care units; §2355, as amended by P.L. 101-508, §4207(b)(4)(B), with respect to waivers for social health maintenance organizations; and §2373(c), with respect to State plans found to be in violation of §1902(a)(10).

See Vol. II, P.L. 99-272, §9221, with respect to the continuation of the "ACCESS: MEDICARE" demonstration project.

See Vol. II, P.L. 99-319, §105, with respect to systems requirements.

See Vol. II, P.L. 99-509, §9412 with respect to waiver authority for chronically mentally ill and frail elderly persons, §9413 with respect to the continuation of "case-managed medical care for nursing home patients" demonstration project, §9414 with respect to the New Jersey respite care pilot project, §9415 with respect to the inapplicability of the Paperwork Reduction Act, §9432, as amended by P.L. 101-508, §4755, with respect to State utilization review systems, and §9436 with respect to the payment for certain long-term care patients in hospitals.

See Vol. II, P.L. 100-203, §4115 with respect to State demonstration projects; §4119 with respect to a study of means of recovering costs of nursing facility services from estates of beneficiaries; §4211(j) with respect to technical assistance; §4211(k) with respect to the report to Congress on staffing requirements; §9116(b) and §9116(c), with respect to retention of medicaid when SSI benefits are lost upon entitlement to early widow's or widower's insurance benefits.

See Vol. II, P.L. 100-204, §724(d), with respect to furnishing information to the United States Commission on Improving the Effectiveness of the United Nations; and §725(b), with respect to the detailing of Government personnel.

See Vol. II, P.L. 100-235, §§5-8, with respect to responsibilities of each Federal agency for computer systems security and privacy.

See Vol. II, P.L. 100-237, §10, with respect to a study of medicaid savings for newborns from the WIC program.

See Vol. II, P.L. 100-360, §303(f), with respect to the State medical assistance plan of Missouri.

See Vol. II, P.L. 100-505, §§201 and 301, with respect to a study and report on assistance.

See Vol. II, P.L. 100-647, §8431, as amended by P.L. 101-239 and P.L. 101-508, with respect to regulations changing the treatment of voluntary contributions or provider-paid taxes utilized to receive matching funds; and §8435, with respect to clarification of Federal financial participation for case-management services.

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APPROPRIATION

SEC. 1901. [42 U.S.C. 1396] For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.[3]

STATE PLANS FOR MEDICAL ASSISTANCE[4]

SEC. 1902. [42 U.S.C. 1396a] (a) A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1903 are authorized by this title; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administra-

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[3] See Vol. II, P.L. 94-437, §402(c), and (d) with respect to services provided to medicaid-eligible Indians and §403 with respect to reports.

[4] See Vol. II, P.L. 93-233, §13(c), with respect to medicaid eligibility for individuals receiving mandatory State supplementary payments.

See Vol. II, P.L. 100-203, §4211(c), with respect to evaluation and report regarding the resident assessment process.

tion and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan,[5] (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, and (C) that each State or local officer or employee who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer or employee, and each partner of such an officer or employee shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18, United States Code;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under title I or XVI (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under title XVI, or by the agency or agencies administering the supplemental security income program established under title XVI or the State plan approved under part A of title IV if the State is not eligible to participate in the State plan program established under title XVI;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1864(a)), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

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[5] P.L. 91-648, §208(a)(3)(D), transferred to the U.S. Civil Service Commission, effective March 6, 1971, all powers, functions, and duties of the Secretary under subparagraph (A). Functions of the Commission were transferred to the Director of the Office of Personnel Management under §102 of Reorganization Plan No. 2 of 1978 (5 U.S.C. 1101 note), effective January 1, 1979.

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1861(e)(9) or paragraphs (15) and (16)[6] of section 1861(s), or, in the case of a laboratory which is in a rural health clinic, of section 1861(aa)(2)(G);

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21)[7] of section 1905(a), to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV (including individuals eligible under this title by reason of section 402(a)(37), 406(h), or 473(b), or considered by the State to be receiving such aid as authorized under section 482(e)(6)[8]),

(II) with respect to whom supplemental security income benefits are being paid under title XVI or who are qualified severely impaired individuals (as defined in section 1905(q)),

(III) who are qualified pregnant women or children as defined in section 1905(n),

(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) for such a family;[9]

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[6] P.L. 99-509, §9320(h)(3), struck out "(11) and (12)" and substituted "(12) and (13)", applicable to services furnished on or after January 1, 1989. For the applicability of this amendment, see Vol. II, P.L. 99-509, §9320(k), as added by P.L. 100-485 and amended by P.L. 101-239.

P.L. 100-203, §4072(d), struck out "(12) and (13)" and substituted "(13) and (14)". For the effective date, see Vol. II, P.L. 100-203, §4072(e).

P.L. 100-360, §204(d)(3), struck out "(13) and (14)" and substituted "(14) and (15)", applicable to screening mammography performed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "(14) and (15)" and substituted "(13) and (14)", effective January 1, 1990.

P.L. 101-239, §6115(c), struck out "(14) and (15)" and substituted "(15) and (16)", applicable to screening pap smears performed on or after July 1, 1990. Executed as if §6115(c) reads "by striking 'paragraphs (13) and (14)'. . .".

[7] P.L. 101-239, §6405(b), struck out "and (17)" and substituted ", (17) and (21)", effective with respect to services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner on or after July 1, 1990.

[8] P.L. 100-485, §202(c)(4), struck out "414(g)" and substituted "482(e)(6)". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

[9] P.L. 100-630, §302(a)(1)(A), added subclause (IV). For the effective date, see Vol. II, P.L. 100-360, §302(f).

P.L. 101-239, §6401(a)(1)(A), struck out "or".

(V) who are qualified family members as defined in section 1905(m)(1),[10]

(VI) who are described in subparagraph (C) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) for such a family, or[11]

(VII) who are described in subparagraph (D) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) for such a family;[12]

(ii) at the option of the State, to any group or groups of individuals described in section 1905(a) (or, in the case of individuals described in section 1905(a)(i), to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under title XVI, or a State supplementary payment;

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1903(f)(4)(C),

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[10] P.L. 100-485, §401(d)(1)(C), added subclause (V), effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992.

P.L. 101-239, §6401(a)(1)(B), struck out the semicolon and substituted ", or".

P.L. 101-508, §4601(a)(1)(A)(i), struck out "or".

[11] P.L. 101-239, §6401(a)(1)(C), added subclause (VI). For the effective date, see Vol. II, P.L. 101-239, §6401(c).

P.L. 101-508, §4601(a)(1)(A)(ii), struck out the semicolon and substituted ", or".

[12] P.L. 101-508, §4601(a)(1)(A)(iii), added subclause (VII). For the effective date, see Vol. II, P.L. 101-508, §4601(b).

(VI) who would be eligible under the State plan under this title if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1915 they would require the level of care provided in a hospital,[13] nursing facility or intermediate care facility for the mentally retarded[14] the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1915,

(VII) who would be eligible under the State plan under this title if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1905(o);

(VIII) who is a child described in section 1905(a)(i)—

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of title IV) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of title IV were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of title IV;[15]

(IX) who are described in subsection (l)(1) and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII)[16];

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[13] P.L. 100-203, §4211(h)(1)(A), struck out "skilled". For the effective date, see Vol. II, P.L. 100-203, §4214.

[14] P.L. 100-203, §4211(h)(1)(A), inserted "for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[15] See Vol. II, P.L. 99-272, §9529(b)(2), with respect to determinations that the requirements of these subdivisions shall be deemed to be met.

[16] P.L. 100-360, §302(a)(1)(B), amended subclause (IX) in its entirety. For the effective date, see Vol. II, P.L. 100-360, §302(f). [For subclause (IX) as it formerly read, see Vol. III, P.L. 100-360.]

P.L. 101-239, §6401(a)(2), inserted "or clause (i)(VI)". For the effective date, see Vol. II, P.L. 101-239, §6401(c).

P.L. 101-508, §4601(a)(1)(B), struck out "or clause (i)(VI)" and substituted ", clause (i)(VI), or clause (i)(VII)". For the effective date, see Vol. II, P.L. 101-508, §4601(b).

(X)[17] who are described in subsection (m)(1); or

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under title XVI), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Secretary under section 1616 or 1634;

(B) that the medical assistance made available to any individual described in subparagraph (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1905(a) who are not described in subparagraph (A) or (E), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance—

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

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[17] P.L. 100-360, §301(e)(2)(A), struck out "subject to subsection (m)(3),", effective July 1, 1989.

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility[18] for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) or the care and services listed in any 7 of the paragraphs numbered (1) through (21)[19] of such section;

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to[20] nursing facility services;[21]

(E)(i)[22] for making medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3)) for qualified medicare beneficiaries described in section 1905(p)(1);[23]

(ii) for making medical assistance available for payment of medicare cost-sharing described in section 1905(p)(3)(A)(i) for qualified disabled and working individuals described in section 1905(s); and[24]

(iii) for making medical assistance available for medicare cost sharing described in section 1905(p)(3)(A)(ii) subject to section 1905(p)(4), for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved;[25] and[26]

(F) at the option of a State, for making medical assistance available for COBRA premiums (as defined in subsection (u)(2)) for qualified COBRA continuation beneficiaries described in section 1902(u)(1);[27]

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[18] P.L. 100-203, §4211(h)(1)(B), struck out "intermediate care facility services" and substituted "in an intermediate care facility". For the effective date, see Vol. II, P.L. 100-203, §4214.

[19] P.L. 101-508, §4711(d)(2), struck out "(20)" and substituted "(21)", applicable to home and community care furnished on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.

P.L. 101-508, §4755(c)(1)(A), made the same amendment, effective July 1, 1990.

[20] P.L. 100-203, §4211(h)(1)(C), struck out "skilled". For the effective date, see Vol. II, P.L. 100-203, §4214.

[21] P.L. 101-508, §4713(a)(1)(A), struck out "and".

[22] P.L. 100-360, §301(a)(1), struck out "at the option of a State, but". For the effective date, see Vol. II, P.L. 100-360, §301(h).

P.L. 100-360, §301(e)(2)(B), struck out "subject to subsection (m)(3),", effective July 1, 1989.

P.L. 101-239, §6408(d)(1)(A), inserted "(i)".

[23] P.L. 101-239, §6408(d)(1)(B), struck out the semicolon and substituted ", and".

P.L. 101-508, §4501(b)(1), struck out ", and" and substituted a semicolon.

[24] P.L. 101-239, §6408(d)(1)(C), added clause (ii). For the effective date, see Vol. II, P.L. 101-239, §6408(d)(5).

P.L. 101-508, §4501(b)(2), added "and".

[25] P.L. 101-508, §4501(b)(3), added clause (iii). For the effective date, see Vol. II, P.L. 101-508, §4501(f).

[26] P.L. 101-508, §4713(a)(1)(B), added "and".

[27] P.L. 101-508, §4713(a)(1)(C), added subparagraph (F), applicable to medical assistance furnished on or after January 1, 1991.

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1916(a)(2) or (b)(2) shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1905(o) to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under title XVIII, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (l)(1)(A) who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or[28] (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy, (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1905(p)(1) who is only entitled to medical assistance because the individual is such a beneficiary[29] shall be limited to medical assistance for medicare cost-sharing (described in section 1905(p)(3)), subject to the provisions of subsection (n) and section 1916(b), (IX) the making available of respiratory care services in accordance with subsection (e)(9) shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A), provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection,[30] (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1923(a)(1)(A), as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals[31]; [32] and[33] (XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1906 shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals [34], and[35] (XI) the medical assistance made available to an individual described in subsection (u)(1) who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2))[36];

(11)(A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan,[37] (B) effective July 1, 1969, provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments under (or through an allotment under) title V, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such title or allotment and which are included in the State plan approved under this section and (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to him under section 1903, and (C) provide for coordination of the operations under this title with the State's operations under the special supplemental food program for women, infants, and children under section 17 of the Child Nutrition Act of 1966[38];

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[28] P.L. 100-360, §302(a)(1)(C), inserted "(A)(i)(IV) or". For the effective date, see Vol. II, P.L. 100-360, §302(f).

[29] P.L. 100-647, §8434(b)(1), inserted "who is only entitled to medical assistance because the individual is such a beneficiary", effective as if included in the enactment of P.L. 100-360, §301.

[30] P.L. 100-360, §302(b)(1)(B), inserted ", and".
P.L. 101-508, §4402(d)(1)(A), struck out "and".
P.L. 101-508, §4713(a)(1)(D), made the same amendment.

[31] P.L. 100-360, §302(b)(1)(B), inserted subclause (X). For the effective date, see Vol. II, P.L. 100-360, §302(f).

[32] See Vol. II, P.L. 93-66, §§230-232, for provisions relating to medicaid.

[33] P.L. 101-508, §4402(d)(1)(B), added "and".

[34] P.L. 101-508, §4402(d)(1)(C), added subdivision (XI). For the effective date, see Vol. II, P.L. 101-508, §4402(e).

[35] P.L. 101-508, §4713(a)(1)(D), added ", and".

[36] P.L. 101-508, §4713(a)(1)(D), added this subdivision (XI), applicable to medical assistance furnished on or after January 1, 1991.

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide—

(A) for payment (except where the State agency is subject to an order under section 1914) of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded[39] provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State which, in the case of nursing facilities, take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title)[40] of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of section 1919 and provide (in the case of a nursing facility with a waiver under section 1919(b)(4)(C)(ii)) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care,[41] and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1861(v)(1)(G)), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1861(v)(1)(G))) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, nursing facility, and intermediate care facility for the mentally retarded and[42] periodic audits by the State of such reports;[43]

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[37] P.L. 101-239, §6406(a)(1), struck out "and".

[38] P.L. 101-239, §6406(a)(1), inserted ", and" and subparagraph (C), effective on July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

[39] P.L. 100-203, §4211(h)(2)(A), struck out ", skilled nursing facility, and intermediate care facility services" and substituted "services, nursing facility services, and services in an intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[40] P.L. 101-508, §4801(e)(1)(A), inserted "(including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title)", effective as if they were included in the enactment of P.L. 100-203.

[41] P.L. 100-203, §4211(b)(sic)(1)(A), inserted "which, in the case of nursing facilities, take into account the costs of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of section 1919 and provide (in the case of a nursing facility with a waiver under section 1919(b)(4)(C)(ii)) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care,". For the effective date, see Vol. II, P.L. 100-203, §4214.

(B) that the State shall provide assurances satisfactory to the Secretary that the payment methodology utilized by the State for payments to hospitals can reasonably be expected not to increase such payments, solely as a result of a change of ownership, in excess of the increase which would result from the application of section 1861(v)(1)(O);

(C) that the State shall provide assurances satisfactory to the Secretary that the valuation of capital assets, for purposes of determining payment rates for nursing facilities and for intermediate care facilities for the mentally retarded[44], will not be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by more than the lesser of—

(i) one-half of the percentage increase (as measured over the same period of time, or, if necessary, as extrapolated retrospectively by the Secretary) in the Dodge Construction Systems Costs for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year, or

(ii) one-half of the percentage increase (as measured over the same period of time) in the Consumer Price Index for All Urban Consumers (United States city average);

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[42] P.L. 100-203, §4211(h)(2)(B) [as amended by P.L. 100-360, §411(l)(3)(J) as added by P.L. 100-485, §608(d)(27)(H)], struck out ", skilled nursing facility, and intermediate care facility and", and substituted ", nursing facility, and intermediate care facility for the mentally retarded and". For the effective date, see Vol. II, P.L. 100-203, §4214.

[43] See Vol. II, P.L. 100-203, §4211(b)(2) [as amended by P.L. 101-508, §4801(e)(1)(B)], with respect to details in plan amendment.

P.L. 101-239, §6411(c)(3), provides that the State of Missouri shall be treated as having met the requirement of this subparagraph (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs) for the period beginning with July 1, 1988, and ending with (and including) June 30, 1990, if the total amount of such payments for such period is not less than the total of such payments otherwise required by law for such period.

[44] P.L. 100-203, §4211(h)(2)(C) [as amended by P.L. 100-360, §411(l)(3)(H)(i)], struck out "skilled nursing facilities and intermediate care facilities" and substituted "nursing facilities and for intermediate care facilities for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

(D) for payment for hospice care in amounts no lower than the amounts, using the same methodology,[45] used under part A of title XVIII and for payment of amounts under section 1905(o)(3); except that in the case of[46] hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded[47], and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded[48] if he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual[49];[50]

(E) for payment for services described in clause (B) or (C) of section 1905(a)(2)[51] under the plan,[52] of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary prescribes[53] in regulations under section

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[45] P.L. 101-239, §6408(c)(1)(A), struck out "the same amounts, and using the same methodology, as" and substituted "amounts no lower than the amounts, using the same methodology,", applicable to services furnished on or after April 1, 1990, without regard to whether or not final regulations have been promulgated by such date to implement this amendment.

[46] P.L. 101-239, §6408(c)(1)(B), struck out "a separate rate may be paid for" and substituted "in the case of", applicable to services furnished on or after April 1, 1990, without regard to whether or not final regulations have been promulgated by such date to implement this amendment.

[47] P.L. 100-203, §4211(h)(2)(D)(i) [as amended by P.L. 100-360, §411(l)(3)(H)(ii)], struck out "skilled nursing facility or intermediate care facility" and substituted "nursing facility or intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[48] P.L. 100-203, §4211(h)(2)(D)(ii) [as amended by P.L. 100-360, §411(l)(3)(H)(iii) and P.L. 100-485, §608(d)(27)(G)], struck out "skilled nursing facility services or intermediate care facility services" and substituted "nursing facility services or services in an intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[49] P.L. 101-239, §6408(c)(1)(C), struck out "to take into account the room and board furnished by such facility" and substituted "there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual", applicable to services furnished on or after April 1, 1990, without regard to whether or not final regulations have been promulgated by such date to implement this amendment.

[50] P.L. 101-508, §4711(c)(1)(A)(i), struck out "and".

[51] P.L. 101-239, §6404(c), struck out "section 1905(a)(2)(B) provided by a rural health clinic" and substituted "clause (B) or (C) of section 1905(a)(2)". For the effective date, see Vol. II, P.L. 101-239, §6404(d).

[52] P.L. 101-239, §6402(c)(2), inserted ", and for payment for services described in section 1905(a)(2)(C) under the plan,", and §6402(d)(2) read as follows:

"(2)(A) The amendments made by subsection (c) apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (c), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.".

P.L. 101-508, §4704(e), in effect, struck out ", and for payment for services described in section 1905(a)(2)(C) under the plan,", effective December 19, 1989, and revised and redesignated P.L. 101-239, §6402(d).

[53] P.L. 101-508, §4704(a)(1), struck out "may prescribe" and substituted "prescribes", effective as if included in the enactment of P.L. 101-239.

1833(a)(3), or, in the case of services to which those regulations do not apply, on the same methodology used under section 1833(a)(3)[54]; and[55]

(F) for payment for home and community care (as defined in section 1929(a) and provided under such section) through rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards;[56]

(14) provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1916;

[(15) Stricken.[57]]

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) except as provided in subsections (l)(3), (m)(3), and (m)(4)[58], include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or to have paid with respect to him supplemental security income benefits under title XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the

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[54] P.L. 101-508, §4704(a)(2), struck out "on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph" and substituted "on the same methodology used under section 1833(a)(3)", effective as if included in the enactment of P.L. 101-239.

[55] P.L. 101-508, §4711(c)(1)(A)(ii), added "and".

[56] P.L. 101-508, §4711(c)(1)(A)(iii), added subparagraph (F), applicable to home and community care furnished on or after July 1, 1991, or, if later, 30 days after the date of publication of interim regulations under §1929(k)(1).

[57] P.L. 100-360, §301(e)(2)(C) [as added by P.L. 100-485, §608(d)(14)(I)(iii); struck out paragraph (15), effective July 1, 1989. [For paragraph (15) as it formerly read, see Vol. III, P.L. 100-360.]

[58] P.L. 100-360, §301(e)(2)(D) [as redesignated by P.L. 100-485, §608(d)(14)(I)(i)], struck out "(m)(4), and (m)(5)" and substituted "(m)(3), and (m)(4)", effective July 1, 1989.

State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under section 1903(f)(2)(B),[59] or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;

(18) comply with the provisions of section 1917 with respect to liens, adjustments and recoveries of medical assistance correctly paid, and transfers of assets;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution; and

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 3(a)(4)(A)(i) and (ii) or section 1603(a)(4)(A)(i) and (ii) which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

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[59] P.L. 101-508, §4723(b), inserted ", payments made to the State under section 1903(f)(2)(B)," effective November 5, 1990.

(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;

(23) except as provided in subsection (g) and in section 1915 and except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1915(b)(1)), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1905(a)(4)(C);

(24) effective July 1, 1969, provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing facilities, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this Act, (B) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this Act, and (C) to provide information needed to determine payments due under this Act on account of care and services furnished to individuals;

(25) provide—

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers) to pay for care and services available under the plan, including—

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall—

(I) be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval system under section 1903(r), and

(II) be subject to the provisions of section 1903(r)(4) relating to reductions in Federal payments for failure to meet conditions of approval, but shall not be subject to any other financial penalty as a result of any other monitoring, quality control, or auditing requirements;

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1916), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1916, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1916) exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1905(a)(4)(B)) covered under the State plan, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);[60]

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of title IV of this Act, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B); and[61]

(G) that the State plan shall meet the requirements of section 1906 (relating to enrollment of individuals under group health plans in certain cases);[62]

(26) if the State plan includes medical assistance for inpatient mental hospital services, provide—

(A) with respect to each patient receiving such services, for a regular program of medical review (including medical evaluation) of his need for such services, and for a written plan of care;

(B) for periodic inspections to be made in all mental institutions within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) of the care being provided to each person receiving medical assistance, including (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the institution, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

(C) for full reports to the State agency by each medical review team of the findings of each inspection under subparagraph (B), together with any recommendations;

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

(28) provide—

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[60] P.L. 101-508, §4402(a)(1)(A), struck out "and".

[61] P.L. 101-508, §4402(a)(1)(B), added "and".

[62] P.L. 101-508, §4402(a)(1)(C), added subparagraph (G). For the effective date, see Vol. II, P.L. 101-508, §4402(e).

(A) that any nursing facility receiving payments under such plan must satisfy all the requirements of subsections (b) through (d) of section 1919 as they apply to such facilities;

(B) for including in "nursing facility services" at least the items and services specified (or deemed to be specified) by the Secretary under section 1919(f)(7) and making available upon request a description of the items and services so included;

(C) for procedures to make available to the public the data and methodology used in establishing payment rates for nursing facilities under this title; and

(D) for compliance (by the date specified in the respective sections) with the requirements of—

(i) section 1919(e)[63];

(ii) section 1919(g) (relating to responsibility for survey and certification of nursing facilities); and

(iii) sections 1919(h)(2)(B) and 1919(h)(2)(D) (relating to establishment and application of remedies);[64]

[(29) Repealed.[65]]

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area[66];

(B) provide, under the program described in subparagraph (A), that—

(i) each admission to a hospital, intermediate care facility for the mentally retarded[67], or hospital for mental diseases is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved, and

(ii) the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 percent of all admissions and must be of sufficient size to serve the purpose of (I) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (II) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted to a hospital, intermediate care facility for the mentally retarded[68], or hospital for mental diseases; and

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[63] P.L. 100-360, §411(l)(3)(E), struck out "1919(f) (relating to implementation of nursing facility requirements, including paragraph (6)(B), relating to specification of resident assessment instrument)" and substituted "1919(e)", effective as if included in the enactment of P.L. 100-203.

[64] P.L. 100-203, §4211(b)(sic)(1)(B), amended paragraph (28) in its entirety. For the effective date, see Vol. II, P.L. 100-203, §4214.

[65] P.L. 101-508, §4801(e)(11)(A), repealed paragraph (29), effective on the date on which the Secretary promulgates standards regarding the qualifications of nursing facility administrators under §1919(f)(4). Until then, paragraph (29) reads as follows:

"(29) include a State program which meets the requirements set forth in section 1908, for the licensing of administrators of nursing homes;".

[66] P.L. 101-239, §6402(a), inserted "and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area", effective December 19, 1989.

[67] P.L. 100-203, §4211(h)(3), struck out "skilled nursing facility, intermediate care facility" and substituted "intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

(C) use a utilization and quality control peer review organization (under part B of title XI), an entity which meets the requirements of section 1152, as determined by the Secretary, or a private accreditation body to conduct (on an annual basis) an independent, external review of the quality of services furnished under each contract under section 1903(m), with the results of such review made available to the State and, upon request, to the Secretary, the Inspector General in the Department of Health and Human Services, and the Comptroller General;

(31) with respect to services in an intermediate care facility for the mentally retarded (where[69] the State plan includes medical assistance for such services) provide—

(A) with respect to each patient receiving such services, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such services;

(B) with respect to each intermediate care facility for the mentally retarded[70] within the State, for periodic onsite inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), including with respect to each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and[71]

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[68] P.L. 100-203, §4211(h)(3), struck out "skilled nursing facility, intermediate care facility" and substituted "intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[69] P.L. 100-203, §4212(d)(2)(A), struck out "skilled nursing facility services (and with respect to intermediate care facility services, where" and substituted "services in an intermediate care facility for the mentally retarded (where". This amendment shall not apply to a State until such date (not earlier than October 1, 1990) as the Secretary determines that the State has specified the resident assessment instrument under §1919(e)(5) and begun conducting surveys under §1919(g)(2).

[70] P.L. 100-203, §4212(d)(2)(B), struck out "skilled nursing or intermediate care facility" and substituted "intermediate care facility for the mentally retarded". This amendment shall not apply to a State until such date (not earlier than October 1, 1990) as the Secretary determines that the State has specified the resident assessment instrument under §1919(e)(5) and begun conducting surveys under §1919(g)(2).

[71] See Vol. II, P.L. 88-164, §107(a)(4), with respect to cited discrepancies.

(C) for full reports to the State agency by each independent professional review team of the findings of each inspection under subparagraph (B), together with any recommendations;

(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—

(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;[72]

(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment; and[73]

(C) in the case of services furnished (during a period that does not exceed 14 continuous days in the case of an informal reciprocal arrangement or 90 continuous days (or such longer period as the Secretary may provide) in the case of an arrangement involving per diem or other fee-for-time compensation) by, or incident to the services of, one physician to the patients of another physician who submits the claim for such services, payment shall be made to the physician submitting the claim (as if the services were furnished by, or incident to, the physician's services), but only if the claim identifies (in a manner specified by the Secretary) the physician who furnished the services.[74]

(33) provide—

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[72] P.L. 101-508, §4708(a)(1), struck out "and".

[73] P.L. 101-508, §4708(a)(2), added "and".

[74] P.L. 101-508, §4708(a)(3), added subparagraph (C), applicable to services furnished on or after November 5, 1990.

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the second sentence of this subsection; and

(B) that, except as provided in section 1919(g),[75] the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this title the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) provide that any disclosing entity (as defined in section 1124(a)(2)) receiving payments under such plan complies with the requirements of section 1124;

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this title, and (B) the major additional conditions which the Secretary finds necessary in the

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[75] P.L. 100-203, §4212(d)(3), inserted ", except as provided in section 1919(d),". This amendment shall not apply to a State until such date (not earlier than October 1, 1990) as the Secretary determines that the State has specified the resident assessment instrument under §1919(e)(5) and begun conducting surveys under §1919(g)(2).

P.L. 100-360, §411(l)(6)(C), struck out "1919(d)" and substituted "1919(g)", effective as if included in the enactment of P.L. 100-203.

interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization;

(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, the information described in section 1128(b)(9);[76]

(39) provide that the State agency shall exclude any specified individual or entity from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1128 or section 1128A, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual or entity during such period;

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1121(a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization;

(41) provide that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board[77] of such action;

(42) provide that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan;

(43) provide for—

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[76] See Vol. II, P.L. 78-410, §1318, with respect to disclosure of financial information required to be supplied under this paragraph.

[77] P.L. 101-508, §4754(a), inserted "and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board", applicable to sanctions effected more than 60 days after November 5, 1990.

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1905(a)(4)(B), of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1905(r)[78],

(B) providing or arranging for the provision of such screening services in all cases where they are requested,[79]

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services, and[80]

(D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:

(i) the number of children provided child health screening services,

(ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services),

(iii) the number of children receiving dental services, and

(iv) the State's results in attaining the participation goals set for the State under section 1905(r);[81]

(44) in each case for which payment for inpatient hospital services, services in an intermediate care facility for the mentally retarded[82], or inpatient mental hospital services is made under the State plan—

(A) a physician (or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician)[83] certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and a physician, a physician assistant under the supervision of a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician,[84] recertifies, where such services are furnished over a period of time, in such cases, at least as often as required under section 1903(g)(6) (or, in the case of services that are services provided in an intermediate care facility[85] for the mentally retarded, every year), and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services, and

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[78] P.L. 101-239, §6403(d)(1), struck out "1905(a)(4)(B)" and substituted "1905(r)", effective April 1, 1990, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

[79] P.L. 101-239, §6403(b)(1), struck out "and".

[80] P.L. 101-239, §6403(b)(2), struck out the semicolon and substituted ", and".

[81] P.L. 101-239, §6403(b)(3), added subparagraph (D), effective April 1, 1990, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

[82] P.L. 100-203, §4212(e)(1)(A), struck out "skilled nursing facility services, intermediate care facility services" and substituted "services in an intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[83] P.L. 100-203, §4218(a)(1)(A), inserted "(or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician)", applicable with respect to certifications or recertifications during the period beginning on July 1, 1988, and ending on October 1, 1990.

(B) such services were furnished under a plan established and periodically reviewed and evaluated by a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with[86] a physician;

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1912;

(46) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act;

(47) at the option of the State, provide for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1920;

(48) provide a method of making cards evidencing eligibility for medical assistance available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(49) provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921;

(50) provide, in accordance with subsection (q), for a monthly personal needs allowance for certain institutionalized individuals and couples;

(51)(A) meet the requirements of section 1924 (relating to protection of community spouses), and (B) meet the requirement of section 1917(c) (relating to transfer of assets);[87]

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[84] P.L. 100-203, §4218(a)(1)(B), struck out "the physician, or a physician assistant or nurse practitioner under the supervision of a physician," and substituted "a physician, a physician assistant under the supervision of a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician,", applicable with respect to certifications or recertifications during the period beginning on July 1, 1988, and ending on October 1, 1990.

[85] P.L. 100-203, §4212(e)(1)(B) [as amended by P.L. 100-360, §411(l)(6)(D)], struck out "intermediate care facility services provided in an institution" and substituted "services provided in an intermediate care facility". For the effective date, see Vol. II, P.L. 100-203, §4214.

[86] P.L. 100-203, §4218(a)(2), inserted "a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with", applicable with respect to certifications or recertifications during the period beginning on July 1, 1988, and ending on October 1, 1990.

[87] P.L. 100-360, §303(e)(4), added paragraph (51). For the effective date, see Vol. II, P.L. 100-360, §303(g).

P.L. 100-485, §303(a)(2)(B), struck out the period and substituted "; and".

P.L. 101-239, §6406(a)(2), struck out "and".

(52) meet the requirements of section 1925 (relating to extension of eligibility for medical assistance);[88]

(53) provide—

(A) for notifying in a timely manner all individuals in the State who are determined to be eligible for medical assistance and who are pregnant women, breastfeeding or postpartum women (as defined in section 17 of the Child Nutrition Act of 1966), or children below the age of 5, of the availability of benefits furnished by the special supplemental food program under such section, and

(B) for referring any such individual to the State agency responsible for administering such program;[89]

(54)(A) provide that, any formulary or similar restriction (except as provided in section 1927(d)) on the coverage of covered outpatient drugs under the plan shall permit the coverage of covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under section 1927(a), which are prescribed for a medically accepted indication (as defined in subsection 1927(k)(6)), and

(B) comply with the reporting requirements of section 1927(b)(2)(A) and the requirements of subsections (d) and (g) of section 1927; and[90]

(55) provide for receipt and initial processing of applications of individuals for medical assistance under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)—

(A) at locations which are other than those used for the receipt and processing of applications for aid under part A of title IV and which include facilities defined as disproportionate share hospitals under section 1923(a)(1)(A) and Federally-qualified health centers described in section 1905(1)(2)(B)[91], and

(B) using applications which are other than those used for applications for aid under such part.[92]

(55) provide, in accordance with subsection (s), for adjusted payments for certain inpatient hospital services;[93]

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[88] P.L. 100-485, §303(a)(2)(C), added paragraph (52), applicable to payments under this title for calendar quarters beginning on or after April 1, 1990 (or, in the case of the Commonwealth of Kentucky, October 1, 1990) (without regard to whether regulations to implement this amendment are promulgated by such date), with respect to families that cease to be eligible for aid under part A of title IV on or after such date.

P.L. 101-239, §6406(a)(3), struck out the period and substituted "; and".

P.L. 101-508, §4401(a)(2)(A), struck out "and".

[89] P.L. 101-239, §6406(a)(4), added paragraph (53), effective July 1, 1990, without regard to whether regulations to carry out this amendment have been promulgated by such date.

P.L. 101-508, §4401(a)(2)(B), struck out a period and substituted "; and".

P.L. 101-508, §4602(a)(1), struck out "and".

P.L. 101-508, §4604(b)(1), made the same amendment as §4602(a)(1).

[90] P.L. 101-508, §4401(a)(2)(C), added paragraph (54), effective November 5, 1990.

P.L. 101-508, §4602(a)(2), struck out a period and substituted "; and".

P.L. 101-508, §4604(b)(2), also struck out a period at the end of "paragraph (54)" and substituted "; and".

[91] Probably should be "1905(l)(2)(B)".

[92] P.L. 101-508, §4602(a)(3), added paragraph (55), applicable to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out this amendments have been promulgated by such date.

[93] P.L. 101-508, §4604(b)(3), added a second paragraph (55), effective with respect to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1991,

(57) provide that each hospital, nursing facility, provider of home health care or personal care services, hospice program, or health maintenance organization (as defined in section 1903(m)(1)(A)) receiving funds under the plan shall comply with the requirements of subsection (w);[94]

(58) provide that the State, acting through a State agency, association, or other private nonprofit entity, develop a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives that would be distributed by providers or organizations under the requirements of subsection (w).[95]

(58) maintain a list (updated not less often than monthly, and containing each physician's unique identifier provided under the system established under subsection (v)) of all physicians who are certified to participate under the State plan.[96]

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X (or title XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)). The provisions of paragraphs (9)(A), (31), and (33) and of section 1903(i)(4) shall not apply to a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV and who for such month was entitled to monthly insurance benefits under title II shall for purposes of this title only be deemed

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without regard to whether or not final regulations to carry out such amendments have been promulgated by such date. Probably should be paragraph (56).

P.L. 101-508, §4751(a)(1)(A), struck out "and".

P.L. 101-508, §4751(a)(1)(B), struck out a period at the end of "paragraph (56)" and substituted "; and". Executed as if this amendment applied to this second paragraph (55).

P.L. 101-508, §4752(c)(1)(A), struck out "and" at the end of "paragraph (56)". Executed as if this amendment applied to this second paragraph (55).

See Vol. II, P.L. 101-508, §4604(d)(2), with respect to a State plan which the Secretary determines requires State legislation.

[94] P.L. 101-508, §4751(a)(1)(C), added paragraph (57), applicable with respect to services furnished on or after December 1, 1991.

P.L. 101-508, §4752(c)(1)(B), struck out a period and substituted ", and" at the end of "paragraph (57)".

[95] P.L. 101-508, §4751(a)(1)(C), added paragraph (58), applicable with respect to services furnished on or after December 1, 1991.

[96] P.L. 101-508, §4752(c)(1)(C), added a second paragraph (58), applicable to medical assistance for calendar quarters beginning more than 60 days after the date of establishment of the physician identifier system under section 1902(x).

to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under title II resulting from enactment of Public Law 92-336 not been applicable to such individual.

The requirement of clause[97] (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement. For purposes of this title, any child who meets the requirements of paragraph (1) or (2) of section 473(b) shall be deemed to be a dependent child as defined in section 406 and shall be deemed to be a recipient of aid to families with dependent children under part A of title IV in the State where such child resides. Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with section 1903(v).[98]

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan—

(1) an age requirement of more than 65 years; or

(2) any residence requirement which excludes any individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address; or

(3) any citizenship requirement which excludes any citizen of the United States.

(c) Notwithstanding subsection (b), the Secretary shall not approve any State plan for medical assistance if—

(1) the State has in effect, under its plan established under part A of title IV, payment levels that are less than the payment levels in effect under such plan on May 1, 1988; or

(2) the State requires individuals described in subsection (l)(1) to apply for benefits under such part as a condition of applying for, or receiving, medical assistance under this title.[99]

(d) If a State contracts with an entity which meets the requirements of section 1152, as determined by the Secretary, for the performance of the quality review functions described in subsection (a)(30)(C), or a utilization and quality control peer review organization having a contract with the Secretary under part B of title XI for the performance of medical or utilization review functions (including quality review functions described in subsection (a)(30)(C)) required under this title of a State plan with respect to specific services or providers (or services or providers in a geographic area of the State), such requirements shall be deemed to be met for those services or providers (or services or providers in that area) by delegation to such an entity or organization under the contract of the State's authority to conduct such review activities if the contract provides for the performance of activities not inconsistent with part B of title XI and provides for such assurances of satisfactory performance by such an entity or organization as the Secretary may prescribe.

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[97] As in original. Possibly should be "subparagraph".

[98] See Vol. II, 31 U.S.C. 3803(c)(2)(C), with respect to benefits not affected by P.L. 100-383.

See Vol. II, P.L. 100-383, §§105(f)(2) and 206(d)(2), with respect to exclusion from income and resources of certain payments to certain individuals.

See Vol. II, P.L. 100-407, §105(c), with respect to the effect of financial assistance under that Act.

See Vol. II, P.L. 100-409, §5, with respect to the effect of this Act on P.L. 92-203 or P.L. 96-487.

See Vol. II, P.L. 100-411, §2(d)(3)(B), with respect to the effect of per capita payments.

[99] P.L. 100-360, §302(c)(1), amended subsection (c) in its entirety. For the effective date, see Vol. II, P.L. 100-360, §302(f). [For subsection (c) as it formerly read, see Vol. III, P.L. 100-360.]

(e)(1)(A) Notwithstanding any other provision of this title, effective January 1, 1974, subject to subparagraph (B)[100] each State plan approved under this title must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of title IV in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this title (as though the family was receiving aid under the plan approved under part A of title IV) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of title IV because of income and resources or hours of work limitations contained in such plan.

(B) Subparagraph (A) shall not apply with respect to families that cease to be eligible for aid under part A of title IV during the period beginning on April 1, 1990, and ending on September 30, 1998. During such period, for provisions relating to extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of title IV and have earned income, see section 1925.[101]

(2)(A) In the case of an individual who is enrolled with a qualified health maintenance organization (as defined in title XIII of the Public Health Service Act[102]) or with an entity described in paragraph (2)(B)(iii), (2)(E), (2)(G), or (6) of section 1903(m) under a contract described in section 1903(m)(2)(A) or with an eligible organization with a contract under section 1876[103] and who would (but for this paragraph) lose eligibility for benefits under this title before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this title, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but, except for benefits furnished under section 1905(a)(4)(C), only with respect to such benefits provided to the individual as an enrollee of such organization or entity.[104]

(B) For purposes of subparagraph (A), the term "minimum enrollment period" means, with respect to an individual's enrollment with an organization or entity under a State plan, a period, established by the State, of not more than six months beginning on the date the individual's enrollment with the organization or entity becomes effective.

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[100] P.L. 100-485, §303(b)(1)(A), inserted "subject to subparagraph (B)", applicable to payments under this title for calendar quarters beginning on or after April 1, 1990 (or, in the case of the Commonwealth of Kentucky, October 1, 1990) (without regard to whether regulations to implement this amendment are promulgated by such date), with respect to families that cease to be eligible for aid under part A of title IV on or after such date.

[101] P.L. 100-485, §303(b)(1)(C), added subparagraph (B), applicable to payments under this title for calendar quarters beginning on or after April 1, 1990 (or, in the case of the Commonwealth of Kentucky, October 1, 1990) (without regard to whether regulations to implement this amendment are promulgated by such date), with respect to families that cease to be eligible for aid under part A of title IV on or after such date.

[102] P.L. 78-410.

[103] P.L. 101-508, §4732(b)(1), inserted "or with an eligible organization with a contract under section 1876", effective November 5, 1990.

[104] See Vol. II, P.L. 100-203, §4113(d), with respect to continued eligibility and restriction on disenrollment without cause for metropolitan health plan HMO's.

(3) At the option of the State, any individual who—

(A) is 18 years of age or younger and qualifies as a disabled individual under section 1614(a);

(B) with respect to whom there has been a determination by the State that—

(i) the individual requires a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded[105],

(ii) it is appropriate to provide such care for the individual outside such an institution, and

(iii) the estimated amount which would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution; and

(C) if the individual were in a medical institution, would be eligible for medical assistance under the State plan under this title,

shall be deemed, for purposes of this title only, to be an individual with respect to whom a supplemental security income payment, or State supplemental payment, respectively, is being paid under title XVI.

(4) A child born to a woman eligible for and receiving medical assistance under a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant)[106] eligible for such assistance. During the period in which a child is deemed under the preceding sentence to be eligible for medical assistance, the medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).

(5) A woman who, while pregnant, is eligible for, has applied for, and has received medical assistance under the State plan, shall continue to be eligible under the plan, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan, through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.

(6) In[107] the case of a pregnant woman described in subsection

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[105] P.L. 100-203, §4211(h)(4), struck out "skilled nursing facility, or intermediate care facility" and substituted "nursing facility, or intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100- 203, §4214.

[106] P.L. 101-508, §4603(a)(1), inserted "(or would remain if pregnant)", applicable to individuals born on or after January 1, 1991, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

[107] P.L. 101-508, §4603(a)(2)(A), struck out "At the option of a State, in" and substituted "In", applicable to determinations to terminate the eligibility of women, based on change of income, made on or after January 1, 1991, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

(a)(10) who, because of a change in income of the family of which she is a member, would not otherwise continue to be described in such subsection, the woman shall be deemed to continue to be[108] an individual described in subsection (a)(10)(A)(i)(IV) and subsection (l)(1)(A) without regard to such change of income through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.[109] The preceding sentence shall not apply in the case of a woman who has been provided ambulatory prenatal care pursuant to section 1920 during a presumptive eligibility period and is then, in accordance with such section, determined to be ineligible for medical assistance under the State plan.[110]

(7) In[111] the case of an infant or child described in subparagraph (B), (C), or (D)[112] of subsection (l)(1) or paragraph (2) of section 1905(n)[113]—

(A) who is receiving inpatient services for which medical assistance is provided on the date the infant or child attains the maximum age with respect to which coverage is provided under the State plan for such individuals, and

(B) who, but for attaining such age, would remain eligible for medical assistance under such subsection,

the infant or child shall continue to be treated as an individual described in such respective provision[114] until the end of the stay for which the inpatient services are furnished.

(8) If an individual is determined to be a qualified medicare beneficiary (as defined in section 1905(p)(1)), such determination shall apply to services furnished after the end of the month in which the determination first occurs. For purposes of payment to a State under section 1903(a), such determination shall be considered to be valid for an individual for a period of 12 months, except that a State may provide for such determinations more frequently, but not more frequently than once every 6 months for an individual.

(9)(A) At the option of the State, the plan may include as medical assistance respiratory care services for any individual who—

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[108] P.L. 101-508, §4603(a)(2)(B), struck out "the State plan may nonetheless treat the woman as being" and substituted "the woman shall be deemed to continue to be", applicable to determinations to terminate the eligibility of women, based on change of income, made on or after January 1, 1991, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

[109] P.L. 100-360, §302(e)(1), amended paragraph (6) in its entirety, applicable to payments under this title for calendar quarters beginning on or after July 1, 1989, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

See Vol. II, P.L. 100-360, §302(f)(3), with respect to delay for State legislation.

[110] P.L. 101-508, §4603(a)(2)(C), added this sentence, applicable to determinations to terminate the eligibility of women, based on change of income, made on or after January 1, 1991, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

[111] P.L. 100-360, §302(e)(2)(A), struck out "If a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX), in" and substituted "In", applicable to payments under this title for calendar quarters beginning on or after July 1, 1989, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

[112] P.L. 101-239, §6401(a)(8), struck out "or (C)" and substituted ", (C), or (D)". For the effective date, see Vol. II, P.L. 101-239, §6401(c).

[113] P.L. 100-360, §302(e)(2)(B), inserted "or paragraph (2) of section 1905(n)", applicable to payments under this title for calendar quarters beginning on or after July 1, 1989, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

[114] P.L. 100-360, §302(e)(2)(C), struck out "subsection (a)(10)(A)(ii)(IX) and subsection (l)(1)" and substituted "such respective provision", applicable to payments under this title for calendar quarters beginning on or after July 1, 1989, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

(i) is medically dependent on a ventilator for life support at least six hours per day;

(ii) has been so dependent for at least 30 consecutive days (or the maximum number of days authorized under the State plan, whichever is less) as an inpatient;

(iii) but for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, nursing facility, or intermediate care facility for the mentally retarded[115] and would be eligible to have payment made for such inpatient care under the State plan;

(iv) has adequate social support services to be cared for at home; and

(v) wishes to be cared for at home.

(B) The requirements of subparagraph (A)(ii) may be satisfied by a continuous stay in one or more hospitals, nursing facilities, or intermediate care facilities for the mentally retarded[116].

(C) For purposes of this paragraph, respiratory care services means services provided on a part-time basis in the home of the individual by a respiratory therapist or other health care professional trained in respiratory therapy (as determined by the State), payment for which is not otherwise included within other items and services furnished to such individual as medical assistance under the plan.

(10)(A) The fact that an individual, child, or pregnant woman may be denied aid under part A of title IV pursuant to section 402(a)(43) shall not be construed as denying (or permitting a State to deny) medical assistance under this title to such individual, child, or woman who is eligible for assistance under this title on a basis other than the receipt of aid under such part.

(B) If an individual, child, or pregnant woman is receiving aid under part A of title IV and such aid is terminated pursuant to section 402(a)(43), the State may not discontinue medical assistance under this title for the individual, child, or woman until the State has determined that the individual, child, or woman is not eligible for assistance under this title on a basis other than the receipt of aid under such part.[117]

(11)(A) In the case of an individual who is enrolled with a group health plan under section 1906 and who would (but for this paragraph) lose eligibility for benefits under this title before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this title, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but only with respect to such benefits provided to the individual as an enrollee of such plan.

(B) For purposes of subparagraph (A), the term "minimum enrollment period" means, with respect to an individual's enrollment with a group health plan, a period established by the State, of not more than 6 months beginning on the date the individual's enrollment under the plan becomes effective.[118]

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[115] P.L. 100-203, §4211(h)(5)(A), struck out "skilled nursing facility, or intermediate care facility," and substituted, "nursing facility, or intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[116] P.L. 100-203, §4211(h)(5)(B), struck out "skilled nursing facilities, or intermediate care facilities" and substituted "nursing facilities, or intermediate care facilities for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[117] P.L. 100-485, §303(d), added paragraph (10), effective January 1, 1990.

(f) Notwithstanding any other provision of this title, except as provided in subsection (e) and section 1619(b)(3) and section 1924[119], except with respect to qualified disabled and working individuals (described in section 1905(s)),[120] and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1)[121], no State not eligible to participate in the State plan program established under title XVI shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1903(f) (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to paragraph (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under paragraph (10)(A), or (2) an eligible individual or eligible spouse, as defined in title XVI, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under paragraph (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to paragraph (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection.

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[118] P.L. 101-508, §4402(c), added paragraph (11). For the effective date, see Vol. II, P.L. 101-508, §4402(e).

[119] P.L. 101-239, §6411(e)(2), inserted "and section 1924", applicable as if included in the enactment of P.L. 100-360, §303.

[120] P.L. 101-239, §6408(d)(4)(C), inserted ", except with respect to qualified disabled and working individuals (described in section 1905(s)),". For the effective date, see Vol. II, P.L. 101-239, §6408(d)(5).

[121] P.L. 101-239, §6411(a)(1), inserted "and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1)", effective as if included in the enactment of P.L. 100-360.

(g) In addition to any other sanction available to a State, a State may provide for a reduction of any payment amount otherwise due with respect to a person who furnishes services under the plan in an amount equal to up to three times the amount of any payment sought to be collected by that person in violation of subsection (a)(25)(C).

(h) Nothing in this title (including subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payment adjustments that may be made under a plan under this title with respect to hospitals that serve a disproportionate number of low-income patients with special needs or to limit the amount of payment that may be made under a plan under this title for home and community care[122].

(i)(1) In addition to any other authority under State law, where a State determines that a[123] intermediate care facility for the mentally retarded[124] which is certified for participation under its plan no longer substantially meets the requirements for such a facility under this title[125] and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, provide

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the requirements for such a facility under this title[126], to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the requirements for such a facility under this title[127], or (B) in the case described in paragraph (1)(B), with the end of the eleventh

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[122] P.L. 101-508, §4711(c)(1)(B), inserted "or to limit the amount of payment that may be made under a plan under this title for home and community care", applicable to home and community care furnished on or after July 1, 1991, or, if later, 30 days after the date of publication of interim regulations under §1929(k)(1).

[123] As in original. Should be "an".

[124] P.L. 100-203, §4213(b)(1)(A) [as amended by P.L. 100-360, §411(l)(8)(C)], struck out "skilled nursing facility or intermediate care facility" and substituted "intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[125] P.L. 100-203, §4213(b)(1)(B) [as amended by P.L. 100-360, §411(l)(8)(C)], struck out "provisions of section 1861(j) or section 1905(c), respectively," and substituted "requirements for such a facility under this title". For the effective date, see Vol. II, P.L. 100-203, §4214.

[126] P.L. 100-203, §4213(b)(1)(C) [as amended by P.L. 100-360, §411(l)(8)(C)], struck out "provisions of section 1861(j) or section 1905(c) (as the case may be)" and substituted "requirements for such a facility under this title". For the effective date, see Vol. II, P.L. 100-203, §4214.

[127] P.L. 100-203, §4213(b)(1)(C) [as amended by P.L. 100-360, §411(l)(8)(C)], struck out "provisions of section 1861(j) or section 1905(c) (as the case may be)" and substituted "requirements for such a facility under this title". For the effective date, see Vol. II, P.L. 100-203, §4214.

month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.

(j) Notwithstanding any other requirement of this title, the Secretary may waive or modify any requirement of this title with respect to the medical assistance program in American Samoa and the Northern Mariana Islands, other than a waiver of the Federal medical assistance percentage, the limitation in section 1108(c), or the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa or the Northern Mariana Islands for care and services described in paragraphs (1) through (22)[128] of section 1905(a).

(k)(1) In the case of a medicaid qualifying trust (described in paragraph (2)), the amounts from the trust deemed available to a grantor, for purposes of subsection (a)(17), is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the grantor, assuming the full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the grantor. For purposes of the previous sentence, the term "grantor" means the individual referred to in paragraph (2).

(2) For purposes of this subsection, a "medicaid qualifying trust" is a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

(3) This subsection shall apply without regard to—

(A) whether or not the medicaid qualifying trust is irrevocable or is established for purposes other than to enable a grantor to qualify for medical assistance under this title; or

(B) whether or not the discretion described in paragraph (2) is actually exercised.

(4) The State may waive the application of this subsection with respect to an individual where the State determines that such application would work an undue hardship.

(l)(1) Individuals described in this paragraph are—

(A) women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy),

(B) infants under one year of age,[129]

(C) children[130] children who have attained one year of age but have not attained 6 years of age, and[131]

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[128] P.L. 101-508, §4711(d)(1), struck out "(21)" and substituted "(22)", applicable to home and community care furnished on or after July 1, 1991, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

P.L. 101-508, §4755(c)(1)(B), made the same amendment, effective July 1, 1990.

[129] P.L. 101-239, §6401(a)(3)(A), struck out "and".

[130] P.L. 101-508, §4601(a)(1)(C)(i), inserted "children". For the effective date, see Vol. II, P.L. 101-508, §4601(b). As in original.

[131] P.L. 101-239, §6401(a)(3)(B), amended subparagraph (C) in its entirety. For the effective date, see Vol. II, P.L. 101-239, §6401(c). [For subparagraph (C) as it formerly read, see Vol. III, P.L. 101-239.]

(D) children born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age,[132]

who are not described in any of subclauses (I) through (III) of[133] subsection (a)(10)(A)(i) and whose family income does not exceed the income level established by the State under paragraph (2) for a family size equal to the size of the family, including the woman, infant, or child.[134]

(2)(A)(i) For purposes of paragraph (1) with respect to individuals described in subparagraph (A) or (B) of that paragraph, the State shall establish an income level which is a percentage (not less than the percentage provided under clause (ii) and[135] not more than 185 percent) of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981[136]) applicable to a family of the size involved.

(ii) The[137] percentage provided under this clause, with respect to eligibility for medical assistance on or after—

(I) July 1, 1989, is 75 percent, or, if greater, the percentage provided under clause (iii),[138] and

(II) April 1, 1990, 133 percent, or, if greater, the percentage provided under clause (iv).[139]

(iii) In the case of a State which, as of the date of the enactment of this clause[140], has elected to provide, and provides, medical assistance to individuals described in this subsection or has enacted legislation authorizing, or appropriating funds, to provide such assistance to such individuals before July 1, 1989, the percentage provided under clause (ii)(I) shall not be less than—

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of the date of the enactment of this clause, or

(II) if no such percentage is specified as of the date of the enactment of this clause, the percentage established under the State's authorizing legislation or provided for under the State's appropriations;

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[132] P.L. 101-508, §4601(a)(1)(C)(ii), amended subparagraph (D in its entirety. For the effective date, see Vol. II, P.L. 101-508, §4601(b). Until then, subparagraph (D) reads as follows:

"(D) at the option of the State,[*] children born after September 30, 1983, who have attained 6 years of age but have not attained 7 or 8 years of age (as selected by the State),".

[*] P.L. 100-360, §302(a)(2)(A)(i), inserted "at the option of the State,". For the effective date, see Vol. II, P.L. 100-360, §302(f).

[133] P.L. 100-360, §302(e)(3)(A), inserted "any of subclauses (I) through (III) of", applicable to payments under this title for calendar quarters beginning on or after July 1, 1989, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

See Vol. II, P.L. 100-360, §302(f)(3), with respect to delay for State legislation.

[134] See Vol. II, P.L. 101-508, §4607(a), with respect to the Secretary's report on State error rates.

[135] P.L. 100-360, §302(a)(2)(B)(i) [as amended by P.L. 100-485, §608(d)(15)(A)(i)], struck out a beginning parenthesis and substituted "(not less than the percentage provided under clause (ii) and". For the effective date, see Vol. II, P.L. 100-360, §302(f).

[136] P.L. 97-35.

[137] P.L. 100-485, §608(d)(15)(B)(i)(I), struck out "Subject to clause (iii), the" and substituted "The", effective as if included in the enactment of P.L. 100-360.

[138] P.L. 100-485, §608(d)(15)(B)(i)(II), inserted "or, if greater, the percentage provided under clause (iii),", effective as if included in the enactment of P.L. 100-360.

[139] P.L. 100-360, §302(a)(2)(B)(iii), added this clause. For the effective date, see Vol. II, P.L. 100-360, §302(f).

P.L. 101-239, §6401(a)(4)(A), amended subclause (II) in its entirety. For the effective date, see Vol. II, P.L. 101-239, §6401(c). [For subclause (II) as it formerly read, see Vol. III, P.L. 101-239.]

[140] July 1, 1988.

but in no case shall this clause require the percentage provided under clause (ii)(I) to exceed 100 percent.[141]

(iv) In the case of a State which, as of the date of the enactment of this clause[142], has established under clause (i), or has enacted legislation authorizing, or appropriating funds, to provide for, a percentage (of the income official poverty line) that is greater than 133 percent, the percentage provided under clause (ii) for medical assistance on or after April 1, 1990, shall not be less than—

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of the date of the enactment of this clause, or

(II) if no such percentage is specified as of the date of the enactment of this clause, the percentage established under the State's authorizing legislation or provided for under the State's appropriations.[143]

(B) For purposes of paragraph (1) with respect to individuals described in subparagraph (C) of such paragraph, the State shall establish an income level which is equal to 133 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.[144]

(C) For purposes of paragraph (1) with respect to individuals described in subparagraph (D) of that paragraph, the State shall establish an income level which is equal to 100 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.[145]

(3) Notwithstanding subsection (a)(17), for individuals who are eligible for medical assistance because of subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII),[146],[147] or[148] (a)(10)(A)(ii)(IX)—

(A) application of a resource standard shall be at the option of the State;

(B) any resource standard or methodology that is applied with respect to an individual described in subparagraph (A) of paragraph (1) may not be more restrictive than the resource standard or methodology that is applied under title XVI;

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[141] P.L. 100-360, §302(a)(2)(B)(iii), added this clause. For the effective date, see Vol. II, P.L. 100-360, §302(f).

[142] December 19, 1989; P.L. 101-239, 103 Stat. 2106.

[143] P.L. 101-239, §6401(a)(4)(B), added clause (iv). For the effective date, see Vol. II, P.L. 101-239, §6401(c).

[144] P.L. 101-239, §6401(a)(6), added this subparagraph (B). For the effective date, see Vol. II, P.L. 101-239, §6401(c).

[145] P.L. 101-508, §4601(a)(1)(C)(iii), amended subparagraph (C) in its entirety. For the effective date, see Vol. II, P.L. 101-508, §4601(b). Until then, subparagraph (C) reads as follows:

"(C)* If a State elects, under subsection (a)(10)(A)(ii)(IX), to cover individuals not described in subparagraph (A) or (B) of paragraph (1), for purposes of that paragraph and with respect to individuals not described in such subparagraphs the State shall establish an income level which is a percentage (not more than 100 percent**) of the income official poverty line described in subparagraph (A).".

*P.L. 101-239, §6401(a)(5)(B), redesignated subparagraph (B) as subparagraph (C).

**P.L. 101-239, §6401(a)(5)(A), struck out ", or, if less, the percentage established under subparagraph (A)". For the effective date, see Vol. II, P.L. 101-239, §6401(c).

[146] P.L. 101-508, §4601(a)(1)(C)(iv), inserted ", (a)(10)(A)(i)(VII),". For the effective date, see Vol. II, P.L. 101-508, §4601(b). As in original. One comma should be deleted.

[147] P.L. 101-239, §6401(a)(6)(sic)(A), inserted ", (a)(10)(A)(i)(VI),". For the effective date, see Vol. II, P.L. 101-239, §6401(c).

[148] P.L. 100-360, §302(e)(3)(B), inserted "(a)(10)(A)(i)(IV) or". For the effective date, see Vol. II, P.L. 100-360, §302(f).

(C) any resource standard or methodology that is applied with respect to an individual described in subparagraph (B), (C), or (D)[149] of paragraph (1) may not be more restrictive than the corresponding methodology that is applied under the State plan under part A of title IV;

(D) the income standard to be applied is the appropriate income standard established under paragraph (2); and

(E) family income shall be determined in accordance with the methodology employed under the State plan under part A or E of title IV (except to the extent such methodology is inconsistent with clause (D) of subsection (a)(17)), and costs incurred for medical care or for any other type of remedial care shall not be taken into account.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(4)(A) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to provide medical assistance for pregnant women and infants under age 1 described in subsection (a)(10)(A)(i)(IV) and for children described in subsection (a)(10)(A)(i)(VI)[150] or subsection (a)(10)(A)(i)(VII)[151] in the same manner as the State would be required to provide such assistance for such individuals if the State had in effect a plan approved under this title.

(B) In the case of a State which is not one of the 50 States or the District of Columbia, the State need not meet the requirement of subsection (a)(10)(A)(i)(IV)[152] (a)(10)(A)(i)(VI), or (a)(10)(A)(i)(VII)[153] and, for purposes of paragraph (2)(A), the State may substitute for the percentage provided under clause (ii) of such paragraph any percentage.[154]

(m)(1) Individuals described in this paragraph are individuals—

(A) who are 65 years of age or older or are disabled individuals (as determined under section 1614(a)(3)),

(B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in paragraph (2)(C)[155]) does not exceed an income level established by the State consistent with paragraph (2)(A), and

(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed (except as provided in paragraph (2)(B)) the maximum amount of resources that an individual may have and obtain benefits under that program.

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[149] P.L. 101-239, §6401(a)(6)(sic)(B), struck out "or (C)" and substituted ", (C), or (D)". For the effective date, see Vol. II, P.L. 101-239, §6401(c).

[150] P.L. 101-239, §6401(a)(7)(A), inserted "and for children described in subsection (a)(10)(A)(i)(VI)". For the effective date, see Vol. II, P.L. 101-239, §6401(c).

[151] P.L. 101-508, §4601(a)(1)(C)(v), inserted "or subsection (a)(10)(A)(i)(VII)". For the effective date, see Vol. II, P.L. 101-508, §4601(b).

[152] As in original. No punctuation.

[153] P.L. 101-239, §6401(a)(7)(B), inserted "or (a)(10)(A)(i)(VI)". For the effective date, see Vol. II, P.L. 101-239, §6401(c).

P.L. 101-508, §4601(a)(1)(C)(vi), struck out "or (a)(10)(A)(i)(VI)" and substituted "(a)(10)(A)(i)(VI), or (a)(10)(A)(i)(VII)". For the effective date, see Vol. II, P.L. 101-508, §4601(b).

[154] P.L. 100-360, §302(c)(2), struck out the former paragraph (4) and §302(d), added this paragraph (4). For the effective date, see Vol. II, P.L. 100-360, §302(f). [For paragraph (4) as it formerly read, see Vol. III, P.L. 100-360.]

[155] P.L. 101-508, §4501(e)(2)(A), inserted ", except as provided in paragraph (2)(C)", applicable to determinations of income for months beginning with January 1991.

(2)(A) The income level established under paragraph (1)(B) may not exceed a percentage (not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981[156]) applicable to a family of the size involved.

(B) In the case of a State that provides medical assistance to individuals not described in subsection (a)(10)(A) and at the State's option, the State may use under paragraph (1)(C) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in subsection (a)(10)(A).

(C) The provisions of section 1905(p)(2)(D) shall apply to determinations of income under this subsection in the same manner as they apply to determinations of income under section 1905(p).[157]

(3)[158] Notwithstanding subsection (a)(17), for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(X)—

(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(4)[159] Notwithstanding subsection (a)(17), for qualified medicare beneficiaries described in section 1905(p)(1)—

(A) the income standard to be applied is the income standard described in section 1905(p)(1)(B)[160], and

(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(n) In the case of medical assistance furnished under this title for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under title XVIII with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

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[156] P.L. 97-35.

[157] P.L. 101-508, §4501(e)(2)(B), added subparagraph (C), applicable to determinations of income for months beginning with January 1991.

[158] P.L. 100-360, §301(e)(2)(E) [as redesignated by P.L. 100-485, §608(d)(14)(I)(ii)], struck out paragraph (3) and redesignated the former paragraph (4) as paragraph (3), effective July 1, 1989. [For paragraph (3) as it formerly read, see Vol. III, P.L. 100-360.]

[159] P.L. 100-360, §301(e)(2)(E) [as redesignated by P.L. 100-485, §608(d)(14)(I)(ii)], redesignated paragraph (5) as paragraph (4), effective July 1, 1989.

[160] P.L. 100-647, §8434(b)(2), struck out "1905(p)(1)(C)" and substituted "1905(p)(1)(B)", effective as if included in the enactment of P.L. 100-360, §301.

(o) Notwithstanding any provision of subsection (a) to the contrary, a State plan under this title shall provide that any supplemental security income benefits paid by reason of subparagraph (E) or (G) of section 1611(e)(1) to an individual who—

(1) is eligible for medical assistance under the plan, and

(2) is in a hospital, skilled nursing facility, or intermediate care facility at the time such benefits are paid,

will be disregarded for purposes of determining the amount of any post-eligibility contribution by the individual to the cost of the care and services provided by the hospital, skilled nursing facility, or intermediate care facility.

(p)(1) In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this title for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII under section 1128, 1128A, or 1866(b)(2).

(2) In order for a State to receive payments for medical assistance under section 1903(a), with respect to payments the State makes to a health maintenance organization (as defined in section 1903(m)) or to an entity furnishing services under a waiver approved under section 1915(b)(1), the State must provide that it will exclude from participation, as such an organization or entity, any organization or entity that—

(A) could be excluded under section 1128(b)(8) (relating to owners and managing employees who have been convicted of certain crimes or received other sanctions),[161]

(B) has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B), or[162]

(C) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services.[163]

(3) As used in this subsection, the term "exclude" includes the refusal to enter into or renew a participation agreement or the termination of such an agreement.

(q)(1)(A) In order to meet the requirement of subsection (a)(50), the State plan must provide that, in the case of an institutionalized individual or couple described in subparagraph (B), in determining the amount of the individual's or couple's income to be applied monthly to payment for the cost of care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the State plan) a monthly personal needs allowance—

(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and

(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in paragraph (2).

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[161] P.L. 101-239, §6411(d)(3)(B)(i), struck out "or".

[162] P.L. 101-239, §6411(d)(3)(B)(ii), struck out the period and substituted ", or".

[163] P.L. 101-239, §6411(d)(3)(B)(iii), added subparagraph (C), applicable to employment and contracts as of March 19, 1990.

(B) In this subsection, the term "institutionalized individual or couple" means an individual or married couple—

(i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this title throughout a month, and

(ii) who is or are determined to be eligible for medical assistance under the State plan.

(2) The minimum monthly personal needs allowance described in this paragraph is $30 for an institutionalized individual and $60 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).

(r)(1) For purposes of sections 1902(a)(17) and 1924(d)(1)(D) and for purposes of a waiver under section 1915, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver[164] there shall be disregarded reparation payments made by the Federal Republic of Germany and[165], there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) medicare and other health insurance premiums, deductibles, or coinsurance, and

(ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this title, subject to reasonable limits the State may establish on the amount of these expenses.

(2)(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI),[166] (a)(10)(A)(i)(VII),[167] (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) or under section 1905(p) may be less restrictive, and shall be no more restrictive, than the methodology—

(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under title XVI, or

(ii) in the case of other groups, under the State plan most closely categorically related.

(B) For purposes of this subsection and subsection (a)(10), methodology is considered to be "no more restrictive" if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.

(s) In order to meet the requirements of subsection (a)(55), the State plan must provide that payments to hospitals under the plan for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital described in section 1923(b)(1), shall—

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[164] As in original. No punctuation.

[165] P.L. 101-508, §4715(a), inserted "there shall be disregarded reparation payments made by the Federal Republic of Germany and", applicable to treatment of income for months beginning with January 1991.

[166] P.L. 101-239, §6401(a)(9), inserted "(a)(10)(A)(i)(VI),". For the effective date, see Vol. II, P.L. 101-239, §6401(c).

[167] P.L. 101-508, §4601(a)(1)(D), inserted "(a)(10)(A)(i)(VII),". For the effective date, see Vol. II, P.L. 101-508, §4601(b).

(1) if made on a prospective basis (whether per diem, per case, or otherwise) provide for an outlier adjustment in payment amounts for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay,

(2) not be limited by the imposition of day limits with respect to the delivery of such services to such individuals, and

(3) not be limited by the imposition of dollar limits (other than such limits resulting from prospective payments as adjusted pursuant to paragraph (1)) with respect to the delivery of such services to any such individual who has not attained their first birthday (or in the case of such an individual who is an inpatient on his first birthday until such individual is discharged).[168]

(t) Except as provided in section 1903(i), nothing in this title (including sections 1903(a) and 1905(a)) shall be construed as authorizing the Secretary to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes (whether or not of general applicability) imposed with respect to the provision of such items or services.[169]

(u)(1) Individuals described in this paragraph are individuals—

(A) who are entitled to elect COBRA continuation coverage (as defined in paragraph (3)),

(B) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed 100 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved,

(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program, and

(D) with respect to whose enrollment for COBRA continuation coverage the State has determined that the savings in expenditures under this title resulting from such enrollment is likely to exceed the amount of payments for COBRA premiums made.

(2) For purposes of subsection (a)(10)(F) and this subsection, the term "COBRA premiums" means the applicable premium imposed with respect to COBRA continuation coverage.

(3) In this subsection, the term "COBRA continuation coverage" means coverage under a group health plan provided by an employer with 75 or more employees provided pursuant to title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974.

(4) Notwithstanding subsection (a)(17), for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(XI)—

(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

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[168] P.L. 101-508, §4604(a), added subsection (s), effective with respect to payments under title XIX for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

See Vol. II, P.L. 101-508, §4604(d)(2), with respect to a State plan which the Secretary determines requires State legislation.

[169] P.L. 101-508, §4701(b)(1), added subsection (t), effective January 1, 1991.

(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(10)(B) or (a)(17), require or permit such treatment for other individuals.[170]

(v)(1) A State plan may provide for the making of determinations of disability or blindness for the purpose of determining eligibility for medical assistance under the State plan by the single State agency or its designee, and make medical assistance available to individuals whom it finds to be blind or disabled and who are determined otherwise eligible for such assistance during the period of time prior to which a final determination of disability or blindness is made by the Social Security Administration with respect to such an individual. In making such determinations, the State must apply the definitions of disability and blindness found in section 1614(a) of the Social Security Act.[171]

(w)(1) For purposes of subsection (a)(57) and sections 1903(m)(1)(A) and 1919(c)(2)(E), the requirement of this subsection is that a provider or organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) to provide written information to each such individual concerning—

(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the provider's or organization's written policies respecting the implementation of such rights;

(B) to document in the individual's medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a nursing facility, at the time of the individual's admission as a resident,

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[170] P.L. 101-508, §4713(a)(2), added subsection (u), applicable to medical assistance furnished on or after January 1, 1991.

[171] P.L. 101-508, §4724(a), added subsection (v)(1), effective November 5, 1990. No paragraph (2) enacted.

(C) in the case of a provider of home health care or personal care services, in advance of the individual coming under the care of the provider,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of a health maintenance organization, at the time of enrollment of the individual with the organization.

(3) Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.

(4) In this subsection, the term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.[172]

(x) The Secretary shall establish a system, for implementation by not later than July 1, 1991, which provides for a unique identifier for each physician who furnishes services for which payment may be made under a State plan approved under this title.[173]

(y)(1) In addition to any other authority under State law, where a State determines that a psychiatric hospital which is certified for participation under its plan no longer meets the requirements for a psychiatric hospital (referred to in section 1905(h)) and further finds that the hospital's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall terminate the hospital's participation under the State plan; or

(B) do not immediately jeopardize the health and safety of its patients, the State may terminate the hospital's participation under the State plan, or provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding, or both.

(2) Except as provided in paragraph (3), if a psychiatric hospital described in paragraph (1)(B) has not complied with the requirements for a psychiatric hospital under this title—

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period, or

(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no Federal financial participation shall be provided under section 1903(a) with respect to further services provided in the hospital until the State finds that the hospital is in compliance with the requirements of this title.

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[172] P.L. 101-508, §4751(a)(2), added subsection (w), applicable with respect to services furnished on or after December 1, 1991.

[173] P.L. 101-508, §4752(a)(1)(A), added subsection (x), effective November 5, 1990.

P.L. 101-508, §4752(a)(1)(B), provides that the system established under this subsection may be the same as, or different from, the system established under P.L. 99-272, §9202(g).

See Vol. II, P.L. 101-508, §4752(d), with respect to foreign medical graduate certification.

(3) The Secretary may continue payments, over a period of not longer than 6 months from the date the hospital is found to be out of compliance with such requirements, if—

(A) the State finds that it is more appropriate to take alternative action to assure compliance of the hospital with the requirements than to terminate the certification of the hospital,

(B) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(C) the State agrees to repay to the Federal Government payments received under this paragraph if the corrective action is not taken in accordance with the approved plan and timetable.[174]

PAYMENT TO STATES

Sec. 1903. [42 U.S.C. 1396b] (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g)[175] and (j) of this section) of the total amount expended during such quarter as medical assistance under the State plan[176]; plus

(2)(A) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency or any other public agency; plus

(B) notwithstanding paragraph (1) or subparagraph (A), with respect to amounts expended for nursing aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) (including the costs for nurse aides to complete such competency evaluation programs)[177], regardless of whether the programs are provided in or outside nursing facilities or of the skill of the personnel involved in such programs, an amount equal to 50 percent (or, for calendar quarters beginning on or after July 1, 1988, and before October[178] 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points)[179] of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such programs; plus[180]

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[174] P.L. 101-508, §4755(a)(2), added subsection (y), effective November 5, 1990.

[175] P.L. 100-203, §4211(g)(2), struck out ", (h),". For the effective date, see Vol. II, P.L. 100-203, §4214.

[176] P.L. 101-508, §4402(d)(3), struck out "(including expenditures for medicare cost-sharing and including expenditures for premiums under part B of title XVIII, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under title XVIII who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof)". For the effective date, see Vol. II, P.L. 101-508, §4402(e).

[177] P.L. 101-239, §6901(b)(5)(A)(i), inserted "(including the costs for nurse aides to complete such competency evaluation programs)", effective as if included in the enactment of P.L. 100-203.

[178] P.L. 101-508, §4801(a)(8), struck out "July" and substituted "October", effective as if included in P.L. 100-203.

(C) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to preadmission screening and resident review activities conducted by the State under section 1919(e)(7); plus[181]

(D) for each calendar quarter during—

(i) fiscal year 1991, an amount equal to 90 percent,
(ii) fiscal year 1992, an amount equal to 85 percent,
(iii) fiscal year 1993, an amount equal to 80 percent, and
(iv) fiscal year 1994 and thereafter, an amount equal to 75 percent,

of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to State activities under section 1919(g); plus[182]

(3) an amount equal to—

(A)(i) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of title XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this title, and

(ii) 90 per centum of so much of the sums expended during any such quarter in the fiscal year ending June 30, 1972, or the fiscal year ending June 30, 1973, as are attributable to the design, development, or installation of cost determination systems for State-owned general hospitals (except that the total amount paid to all States under this clause for either such fiscal year shall not exceed $150,000), and

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; and

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[179] P.L. 101-239, §6901(b)(5)(A)(ii), inserted "(or, for calendar quarters beginning on or after July 1, 1988, and before July 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points)", effective as if included in the enactment of P.L. 100-203.

[180] P.L. 100-203, §4211(d)(1)(B), added this subparagraph. For the effective date, see Vol. II, P.L. 100-203, §4214.

[181] P.L. 100-203, §4211(d)(1)(B), added this subparagraph. For the effective date, see Vol. II, P.L. 100-203, §4214.

[182] P.L. 100-203, §4212(c)(1), added this subparagraph. For the effective date, see Vol. II, P.L. 100-203, §4214.

See Vol. II, P.L. 100-203, §4211(d)(2), with respect to enhanced funding for nurse aide training.

(C) 75 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of medical and utilization review or quality review by a utilization and quality control peer review organization or by an entity which meets the requirements of section 1152, as determined by the Secretary, under a contract entered into under section 1902(d); and[183]

(D) 75 percent of so much of the sums expended by the State plan during a quarter in 1991, 1992, or 1993, as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of section 1927(g); plus[184]

(4) an amount equal to 100 percent of the sums expended during the quarter which are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus

(5) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the offering, arranging, and furnishing (directly or on a contract basis) of family planning services and supplies;

(6) subject to subsection (b)(3), an amount equal to—

(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and

(B) 75 per centum of the sums expended during each succeeding calendar quarter,

with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to the establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (q)); plus

(7) subject to section 1919(g)(3)(B),[185] an amount equal to 50 per centum of the remainder of the amounts expended during such

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[183] P.L. 101-508, §4401(b)(1)(A), struck out "plus" and substituted "and".

[184] P.L. 101-508, §4401(b)(1)(B), added subparagraph (D), effective November 5, 1990.

[185] P.L. 100-203, §4212(e)(2), inserted "subject to section 1919(g)(3)(B),". For the effective date, see Vol. II, P.L. 100-203, §4214.

quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.[186]

(b)(1) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter beginning after December 31, 1969, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under title XVIII which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of title XVIII, other than amounts expended under provisions of the plan of such State required by section 1902(a)(34).

(2) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

(3) The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a)(6) may not exceed the higher of—

(A) $125,000, or

(B) one-quarter of 1 per centum of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this title.

(c) Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a handicapped child because such services are included in the child's individualized education program established pursuant to part B of the Education of the Handicapped Act[187] or furnished to a handicapped infant or toddler because such services are included in the child's individualized family service plan adopted pursuant to part H of such Act.

(d)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2)(A) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

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[186] See Vol. II, P.L. 100-203, §4212(c)(3), with respect to proper expenses.

See Vol. II, P.L. 101-239, §6411(g), with respect to day habilitation and related services; and §6901(d)(2), with respect to clarification of Federal matching rate for survey and certification activities .

See Vol. II, P.L. 101-508, §4401(b)(2), with respect to the temporary increase in the Federal match.

[187] P.L. 91-230; Title VI.

P.L. 101-476, §901(c)(3), provides that any other Act and any regulation which refers to the Education of the Handcapped Act shall be considered to refer to the Individuals with Disabilities Education Act.

(B) Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1902(a)(25).

(C) For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 60 days in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 60 days, whether or not recovery was made.

(D) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).

(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(4) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(5) In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under section 1116(d), and such State disputes such disallowance, the amount of the Federal payment in controversy shall, at the option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount. If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent payments made to such State under this title, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount was disallowed and ending on the date of such final determination at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day treasury bill auction rates during such period.

(e) A State plan approved under this title may include, as a cost with respect to hospital services under the plan under this title, periodic expenditures made to reflect transitional allowances established with respect to a hospital closure or conversion under section 1884.

(f)(1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

(B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133 1/3 percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of title IV of this Act.

(ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.[188]

(C) The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of $100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of $100 or such other amount, as the case may be.

(2)(A)[189] In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred by such family for medical care or for any other type of remedial care recognized under State law or, (B) notwithstanding section 1916 at State option, an amount paid by such family, at the family's option, to the State, provided that the amount, when combined with costs incurred in prior months, is sufficient when excluded from the family's income to reduce such family's income below the applicable income limitation described in paragraph (1). The amount of State expenditures for which medical assistance is available under subsection (a)(1) will be reduced by amounts paid to the State pursuant to this subparagraph.[190].

(3) For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of title IV of this Act shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan provided for aid to such a family.

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual de-

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[188] See Vol. II, P.L. 100-203, §4106, with respect to medically needy income levels for certain two-member couples in California.

See Vol. II, P.L. 101-508, §4718, with respect to medically needy income levels for certain one-member families.

[189] P.L. 101-508, §4723(a)(1), redesignated paragraph (2) as subparagraph (A), effective November 5, 1990.

[190] P.L. 101-508, §4723(a)(2), added "or," and subparagraph (B), effective November 5, 1990. As in original. One period should be deleted.

scribed in section 1902(a)(10)(A)(i)(III), 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(V),[191] 1902(a)(10)(A)(i)(VI),[192] 1902(a)(10)(A)(i)(VII),[193] 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), or 1905(p)(1) or for any individual—

(A) who is receiving aid or assistance under any plan of the State approved under title I, X, XIV or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or

(B) who is not receiving such aid or assistance, and with respect to whom such benefits are not being paid, but (i) is eligible to receive such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or assistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), but only if the income of such individual (as determined under section 1612, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1),

at the time of the provision of the medical assistance giving rise to such expenditure.

(g)(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1876 or which is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act[194])), the Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services or services in an intermediate care facility for the mentally retarded[195] for 60 days[196] or inpatient mental hospital services for 90 days (whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services or services in an intermediate care facility for the mentally retarded[197] furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals and intermediate care facilities for the mentally retarded[198] pursuant to paragraphs (26) and (31) of section 1902(a) whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams. In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1812.

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[191] P.L. 101-508, §4601(a)(3)(A)(i), struck out "1902(a)(10)(A)(i)(IV)," and substituted "1902(a)(10)(A)(i)(III), 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(V),". For the effective date, see Vol. II, P.L. 101-508, §4601(b).

[192] P.L. 101-239, §6401(b), inserted "1902(a)(10)(A)(i)(VI),". For the effective date, see Vol. II, P.L. 101-239, §6401(c).

[193] P.L. 101-508, §4601(a)(3)(A)(ii), inserted "1902(a)(10)(A)(i)(VII),". For the effective date, see Vol. II, P.L. 101-508, §4601(b).

[194] P.L. 78-410.

[195] P.L. 100-203, §4212(d)(1)(A)(i), struck out "intermediate care facility services" and substituted "services in an intermediate care facility for the mentally retarded". This amendment shall not apply to a State until such date (not earlier than October 1, 1990) as the Secretary determines that the State has specified the resident assessment instrument under §1919(e)(5) and begun conducting surveys under §1919(g)(2).

[196] P.L. 100-203, §4212(d)(1)(A)(ii), struck out ", skilled nursing facility services for 30 days,". This amendment shall not apply to a State until such date (not earlier than October 1, 1990) as the Secretary determines that the State has specified the resident assessment instrument under §1919(e)(5) and begun conducting surveys under §1919(g)(2).

(2) The Secretary shall, as part of his validation procedures under this subsection, conduct timely sample onsite surveys of private and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this title, and his findings with respect to such surveys (as well as the showings of the State agency required under this subsection) shall be made available for public inspection.

(3)(A) No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect—

(i) if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning before January 1, 1977;

(ii) before January 1, 1978;

(iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes effect; or

(iv) due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after September 30, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.

(B) The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State, made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before January 1, 1978, is determined to be either unsatisfactory under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to any calendar quarter ending on or before December 31, 1978, is satisfactory under such paragraph and is valid under paragraph (2).

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[197] P.L. 100-203, §4212(d)(1)(A)(iii), struck out ", skilled nursing facility services, or intermediate care facility services" and substituted "or services in an intermediate care facility for the mentally retarded". This amendment shall not apply to a State until such date (not earlier than October 1, 1990) as the Secretary determines that the State has specified the resident assessment instrument under §1919(e)(5) and begun conducting surveys under §1919(g)(2).

[198] P.L. 100-203, §4212(d)(1)(A)(iv), struck out ", skilled nursing facilities, and intermediate care facilities" and substituted "and intermediate care facilities for the mentally retarded". This amendment shall not apply to a State until such date (not earlier than October 1, 1990) as the Secretary determines that the State has specified the resident assessment instrument under §1919(e)(5) and begun conducting surveys under §1919(g)(2).

(4)(A) The Secretary may not find the showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter, unless the State demonstrates to the satisfaction of the Secretary good cause for not meeting such deadline.

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals and intermediate care facilities for the mentally retarded[199] under paragraphs (26) and (31) of section 1902(a), if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—

(i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and

(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

(5) In the case of a State's unsatisfactory or invalid showing made with respect to a type of facility or institutional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1) is equal to 33 1/3 per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the State plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of such patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter.

(6)(A) Recertifications required under section 1902(a)(44) shall be conducted at least every 60 days in the case of inpatient hospital services.

(B)[200] Such recertifications in the case of services in an intermediate care facility for the mentally retarded[201] shall be conducted at least—

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[199] P.L. 100-203, §4212(d)(1)(B), struck out ", skilled nursing facilities, and intermediate care facilities" and substituted "and intermediate care facilities for the mentally retarded". This amendment shall not apply to a State until such date (not earlier than October 1, 1990) as the Secretary determines that the State has specified the resident assessment instrument under §1919(e)(5) and begun conducting surveys under §1919(g)(2).

[200] P.L. 100-203, §4212(d)(1)(C)(i), struck out subparagraph (B) and §4212(d)(1)(C)(iii) redesignated subparagraph (C) as subparagraph (B). This amendment shall not apply to a State until such date (not earlier than October 1, 1990) as the Secretary determines that the State has specified the resident assessment instrument under §1919(e)(5) and begun conducting surveys under §1919(g)(2).

[201] P.L. 100-203, §4212(d)(1)(C)(ii), struck out "intermediate care facility services" and substituted "services in an intermediate care facility for the mentally retarded". This amendment shall not apply to a State until such date (not earlier than October 1, 1990) as the Secretary determines that the State has specified the resident assessment instrument under §1919(e)(5) and begun conducting surveys under §1919(g)(2).

(i) 60 days after the date of the initial certification,
(ii) 180 days after the date of the initial certification,
(iii) 12 months after the date of the initial certification,
(iv) 18 months after the date of the initial certification,
(v) 24 months after the date of the initial certification, and
(vi) every 12 months thereafter.

(C) For purposes of determining compliance with the schedule established by this paragraph, a recertification shall be considered to have been done on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required and the State establishes good cause why the physician or other person making such recertification did not meet such schedule.

[(7) Stricken.[202]**]**

[(h) Stricken.[203]**]**

(i) Payment under the preceding provisions of this section shall not be made—

(1) for organ transplant procedures unless the State plan provides for written standards respecting the coverage of such procedures and unless such standards provide that—

(A) similarly situated individuals are treated alike; and

(B) any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan; or

(2) with respect to any amount expended for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital[204]) furnished—

(A) under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2), or

(B) at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

(3) with respect to any amount expended for inpatient hospital services furnished under the plan (other than amounts attributable to the special situation of a hospital which serves a disproportionate number of low income patients with special needs) to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free

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[202] P.L. 100-203, §4212(d)(1)(D), struck out paragraph (7). This amendment shall not apply to a State until such date (not earlier than October 1, 1990) as the Secretary determines that the State has specified the resident assessment instrument under §1919(e)(5) and begun conducting surveys under §1919(g)(2).

[203] P.L. 100-203, §4211(g)(1), struck out subsection (h). For the effective date, see Vol. II, P.L. 100-203, §4214.

[204] P.L. 101-239, §6411(d)(2), inserted ", not including items or services furnished in an emergency room of a hospital", effective December 19, 1989.

of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for care or services furnished under the plan by a hospital[205] unless such hospital[206] has in effect a utilization review plan which meets the requirements imposed by section 1861(k) for purposes of title XVIII; and if such hospital[207] has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k); or

(5) with respect to any amount expended for any drug product for which payment may not be made under part B of title XVIII because of section 1862(c)[208]; or

(6) with respect to any amount expended for inpatient hospital tests (other than in emergency situations) not specifically ordered by the attending physician or other responsible practitioner; or

(7) with respect to any amount expended for clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital, to the extent such amount exceeds the amount that would be recognized under section 1833(h) for such tests performed for an individual enrolled under part B of title XVIII; or

(8) with respect to any amount expended for medical assistance (A)[209] for nursing facility services to reimburse (or otherwise compensate) a nursing facility for payment of a civil money penalty imposed under section 1919(h) or (B) for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under this title or title XI or for legal expenses in defense of an exclusion or civil money penalty under this title or title XI if there is no reasonable legal ground for the provider's case[210]; or[211]

(9) with respect to any amount of medical assistance for pregnant women and children described in section

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[205] P.L. 100-203, §4211(i), struck out "or skilled nursing facility". For the effective date, see Vol. II, P.L. 100-203, §4214.

[206] P.L. 100-203, §4211(i), struck out "or skilled nursing facility". For the effective date, see Vol. II, P.L. 100-203, §4214.

[207] P.L. 100-203, §4211(i), struck out "or skilled nursing facility". For the effective date, see Vol. II, P.L. 100-203, §4214.

[208] P.L. 101-234, §201(a)(1), struck out "(1)", effective January 1, 1990.

[209] P.L. 101-508, §4711(c)(2), inserted "(A)", applicable to civil money penalties imposed after November 5, 1990.

[210] P.L. 101-508, §4711(c)(2), added "or" and subparagraph (B), applicable to civil money penalties imposed after November 5, 1990.

[211] P.L. 100-203, §4213(b)(2), added paragraph (8). For the effective date, see Vol. II, P.L. 100-203, §4214.

P.L. 100-360, §302(c)(3)(A), struck out a period and substituted "; or".

1902(a)(10)(A)(ii)(IX), if the State has in effect, under its plan established under part A of title IV, payment levels that are less than the payment levels in effect under such plan on July 1, 1987;[212]

(10) with respect to covered outpatient drugs of a manufacturer dispensed in any State unless, (A) except as provided in section 1927(a)(3), the manufacturer complies with the rebate requirements of section 1927(a) with respect to the drugs so dispensed in all States, and (B) effective January 1, 1993, the State provides for drug use review in accordance with section 1927(g); or[213]

(10) with respect to any amount expended for medical assistance for care or services furnished by a hospital, nursing facility, or intermediate care facility for the mentally retarded to reimburse the hospital or facility for the costs attributable to taxes imposed by the State soley [214]with respect to hospitals or facilities.[215]

(11) with respect to any amount expended to reimburse (or otherwise compensate) a nursing facility for payment of legal expenses associated with any action initiated by the facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action; or [216]

(12) with respect to any amount expended for physicians' services furnished on or after the first day of the first quarter beginning more than 60 days after the date of establishment of the physician identifier system under section 1902(x), unless the claim for the services includes the unique physician identifier provided under such system.[217] [218]

(14) with respect to any amount expended for physicians' services furnished by a physician on or after January 1, 1992, to—

(A) a child under 21 years of age, unless the physician—

(i) is certified in family practice or pediatrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or pediatrics,

(ii) is employed by, or affiliated with, a Federally-qualified health center (as defined in section 1905(l)(2)(B)),

(iii) holds admitting privileges at a hospital participating in a State plan approved under this title,

(iv) is a member of the National Health Service Corps,

(v) documents a current, formal, consultation and referral arrangement with a pediatrician or family practitioner who has the certification described in clause (i) for purposes of specialized treatment and admission to a hospital, or

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[212] P.L. 101- 508, §4401(a)(1)(A), struck out a period and substituted "; or".

P.L. 101-508, §4701(b)(2)(A), made the same amendment.

P.L. 101- 508, §4801(e)(16)(A)(i), struck out "or".

[213] P.L. 101-508, §4401(a)(1)(B), added paragraph (10), effective November 5, 1990.

P.L. 101-508, §4801(e)(16)(A)(ii), struck out a period and substituted "; or".

[214] As in original. Probably should be "solely".

[215] P.L. 101-508, §4701(b)(2)(B), added a second paragraph (10), effective January 1, 1991.

[216] P.L. 101-508, §4752(a)(2)(A), struck out a period and substituted "; or".

P.L. 101-508, §4801(e)(16)(A)(iii), added paragraph (11), applicable to actions initiated on or after November 5, 1990.

[217] P.L. 101-508, §4752(a)(2)(B), added paragraph (12), effective November 5, 1990.

[218] P.L. 101-508, §4752(e)(1), struck out a period "at the end of paragraph (13)" and substituted "; or". No paragraph (13) enacted.

(vi) has been certified by the Secretary as qualified to provide physicians' services to a child under 21 years of age; or

(B) to a pregnant woman (or during the 60 day period beginning on the date of termination of the pregnancy) unless the physician—

(i) is certified in family practice or obstetrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or obstetrics,

(ii) is employed by, or affiliated with, a Federally-qualified health center (as defined in section 1905(l)(2)(B)),

(iii) holds admitting privileges at a hospital participating in a State plan approved under this title,

(iv) is a member of the National Health Service Corps,

(v) documents a current, formal, consultation and referral arrangement with an obstetrician or family practitioner who has the certification described in clause (i) for purposes of specialized treatment and admission to a hospital, or

(vi) has been certified by the Secretary as qualified to provide physicians' services to pregnant women.[219]

Nothing in paragraph (1) shall be construed as permitting a State to provide services under its plan under this title that are not reasonable in amount, duration, and scope to achieve their purpose.

(j) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 1914.

(k) The Secretary is authorized to provide at the request of any State (and without cost to such State) such technical and actuarial assistance as may be necessary to assist such State to contract with any health maintenance organization which meets the requirements of subsection (m) of this section for the purpose of providing medical care and services to individuals who are entitled to medical assistance under this title.

[(l) Repealed.[220]]

(m)(1)(A) The term "health maintenance organization" means a public or private organization, organized under the laws of any State, which meets the requirement of section 1902(w)[221] is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act[222]) or which meets the requirement of section 1902(a) and[223]—

(i) makes services it provides to individuals eligible for benefits under this title accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for medical assistance under the State plan) not enrolled with the organization, and

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[219] P.L. 101-508, §4752(e)(2), added paragraph (14), effective November 5, 1990.

[220] P.L. 94-552, §1; 90 Stat. 2540.

[221] P.L. 101-508, §4751(b)(1)(A), inserted "meets the requirement of section 1902(w)", applicable to services furnished on or after December 1, 1991.

[222] P.L. 78-410.

[223] P.L. 101-508, §4751(b)(1)(B), inserted "meets the requirement of section 1902(a) and", applicable to services furnished on or after December 1, 1991.

(ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State and which assures that individuals eligible for benefits under this title are in no case held liable for debts of the organization in case of the organization's insolvency.

(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a health maintenance organization within the meaning of subparagraph (A), shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

(2)(A) Except as provided in subparagraphs (B), (C), and (G), no payment shall be made under this title to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization) which is responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1905(a) or for the provision of any three or more of the services described in such paragraphs unless—

(i) the Secretary[224] has determined that the entity is a health maintenance organization as defined in paragraph (1);

(ii) less than 75 percent of the membership of the entity which is enrolled on a prepaid basis consists of individuals who (I) are insured for benefits under part B of title XVIII or for benefits under both parts A and B of such title, or (II) are eligible to receive benefits under this title;[225]

(iii) such services are provided for the benefit of individuals eligible for benefits under this title in accordance with a contract between the State and the entity under which prepaid payments to the entity are made on an actuarially sound basis and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of $100,000;

(iv) such contract provides that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain (I) to the ability of the entity to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

(v) such contract provides that in the entity's enrollment, reenrollment, or disenrollment of individuals who are eligible for benefits under this title and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services;

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[224] P.L. 101-508, §4732(d)(1), struck out "(or the State as authorized by paragraph (3))", effective November 5, 1990.

[225] P.L. 101-239, §6411(f), directs the Secretary to continue to waive, through June 30, 1992, the application of this clause to the Tennessee Primary Care Network, Inc., under the same terms and conditions as applied to such waiver as of July 1, 1989.

(vi) such contract (I) except as provided under subparagraph (F), permits individuals who have elected under the plan to enroll with the entity for provision of such benefits to terminate such enrollment without cause as of the beginning of the first calendar month following a full calendar month after the request is made for such termination, and (II) provides for notification of each such individual, at the time of the individual's enrollment, of such right to terminate such enrollment;

(vii) such contract provides that, in the case of medically necessary services which were provided (I) to an individual enrolled with the entity under the contract and entitled to benefits with respect to such services under the State's plan and (II) other than through the organization because the services were immediately required due to an unforeseen illness, injury, or condition, either the entity or the State provides for reimbursement with respect to those services,[226]

(viii) such contract provides for disclosure of information in accordance with section 1124 and paragraph (4) of this subsection;[227]

(ix) such contract provides, in the case of an entity that has entered into a contract for the provision of services of such center with a federally qualified health center, that (I) rates of prepayment from the State are adjusted to reflect fully the rates of payment specified in section 1902(a)(13)(E), and (II) at the election of such center payments made by the entity to such a center for services described in 1905(a)(2)(C) are made at the rates of payment specified in section 1902(a)(13)(E);[228]

(x) any physician incentive plan that it operates meets the requirements described in section 1876(i)(8); and[229]

(xi) such contract provides for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients.[230]

(B) Subparagraph (A) except with respect to clause (ix) of subparagraph (A),[231] does not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

(i)(I) received a grant of at least $100,000 in the fiscal year ending June 30, 1976, under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act[232], and for the period beginning July 1,

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[226] P.L. 101-508, §4704(a)(1)(A), struck out "and".

[227] P.L. 101-508, §4704(b)(1)(B), struck out a period and inserted ", and".

P.L. 101-508, §4731(a)(1), struck out ", and" and substituted a semicolon.

[228] P.L. 101-508, §4704(b)(1)(C), added clause (ix), effective as if included in the enactment of P.L. 101-239.

Margin as in original.

P.L. 101-508, §4731(a)(2), struck out a period and substituted "; and".

P.L. 101-508, §4752(b)(1)(A), struck out "and".

[229] P.L. 101-508, §4731(a)(3), added clause (x), applicable to contract years beginning on or after January 1, 1992.

P.L. 101-508, §4752(b)(1)(B), struck out a period and substituted "; and".

[230] P.L. 101-508, §4752(b)(1)(C), added clause (xi), applicable to contract years beginning after the date of the establishment of the system described in §1902(x).

See Vol. II, P.L. 99-272, §9517(c)(2)(C), with respect to the Hartford Health Network, Inc.; and §9517(c)(2)(D), with respect to health maintenance organization laws of a State.

See Vol. II, P.L. 99-272, §9517(c)(2)(A) and (3) [as amended by P.L. 101-508, §4734], with respect to certain county-operated health insuring organizations.

[231] P.L. 101-508, §4704(b)(2), inserted "except with respect to clause (ix) of subparagraph (A),", effective as if included in the enactment of P.L. 101-239.

[232] P.L. 78-410.

1976, and ending on the expiration of the period for which payments are to be made under this title has been the recipient of a grant under either such section; and

(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) and, to the extent required by section 1902(a)(10)(D) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a); or

(ii) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

(I) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965[233], and

(II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this title on a prepaid capitation risk basis or on any other risk basis; or

(iii) which has contracted with the single State agency for the provision of services (but not including inpatient hospital services) to persons eligible under this title on a prepaid risk basis prior to 1970.

(C) Subparagraph (A)(ii) shall not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on the date of enactment of this subsection[234] or beginning on the date the entity qualifies as a health maintenance organization (as determined by the Secretary), whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)(ii).

(D) In the case of a health maintenance organization that is a public entity, the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Secretary determines that[235] the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under this title or under title XVIII.

(E) In the case of a health maintenance organization that—

(i) is a nonprofit organization with at least 25,000 members,

(ii) is and has been a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act[236]) for a period of at least four years,

(iii) provides basic health services through members of the staff of the organization,

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[233] P.L. 89-4; see 40 U.S.C. App. 214, 303.

[234] October 8, 1976 [P.L. 94-460; 90 Stat. 1945, at 1959].

[235] P.L. 101-508, §4732(a), struck out "(i) special circumstances warrant such modification or waiver, and (ii)", effective November 5, 1990.

[236] P.L. 78-410.

(iv) is located in an area designated as medically underserved under section 1302(7) of the Public Health Service Act, and

(v) previously received a waiver of the requirement described in subparagraph (A)(ii) under section 1115,

the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Secretary determines that special circumstances warrant such modification or waiver and that the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under this title or under title XVIII.

(F) In the case of—

(i) a contract with an entity described in subparagraph (E) or (G),[237] with a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) which meets the requirement of subparagraph (A)(ii), or or[238] with an eligible organization with a contract under section 1876 which meets the requirement of subparagraph (A)(ii), or[239]

(ii) a program pursuant to an undertaking described in paragraph (6) in which at least 25 percent of the membership enrolled on a prepaid basis are individuals who (I) are not insured for benefits under part B of title XVIII or eligible for benefits under this title, and (II) (in the case of such individuals whose prepayments are made in whole or in part by any government entity) had the opportunity at the time of enrollment in the program to elect other coverage of health care costs that would have been paid in whole or in part by any governmental entity,

a State plan may restrict the period in which requests for termination of enrollment without cause under subparagraph (A)(vi)(I) are permitted to the first month of each period of enrollment, each such period of enrollment not to exceed six months in duration, but only if the State provides notification, at least twice per year, to individuals enrolled with such entity or organization of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to requests for termination of enrollment for cause.[240]

(G) In the case of an entity which is receiving (and has received during the previous two years) a grant of at least $100,000 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act or is receiving (and has received during the previous two years) at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965[241], clauses (i) and (ii) of subparagraph (A) shall not apply.

(H) In the case of an individual who—

(i) in a month is eligible for benefits under this title and enrolled with a health maintenance organization with a contract under this paragraph,

(ii) in the next month (or in the next 2 months) is not eligible for such benefits, but

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[237] P.L. 101-508, §4732(b)(2)(A), struck out "or" and substituted a comma, effective November 5, 1990.

[238] One "or" should be deleted.

[239] P.L. 101-508, §4732(b)(2)(B), added "or with an eligible organization with a contract under section 1876 which meets the requirement of subparagraph (A)(ii), or", effective November 5, 1990.

[240] See Vol. II, P.L. 100-203, §4113(d), with respect to continued eligibility and restriction on disenrollment without cause for metropolitan health plan HMO's.

[241] P.L. 89-4; see 40 U.S.C. App. 214, 303.

(iii) in the succeeding month is again eligible for such benefits, the State plan, subject to subparagraph (A)(vi), may enroll the individual for that succeeding month with the health maintenance organization described in clause (i) if the organization continues to have a contract under this paragraph with the State.[242]

[(3) Stricken.[243]**]**

(4)(A) Each health maintenance organization which is not a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act[244]) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General a description of transactions between the organization and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

(i) Any sale or exchange, or leasing of any property between the organization and such a party.

(ii) Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

(iii) Any lending of money or other extension of credit between the organization and such a party.

The State or Secretary may require that information reported respecting an organization which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(B) Each organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

(5)(A) If the Secretary determines that an entity with a contract under this subsection—

(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(ii) imposes premiums on individuals enrolled under this subsection in excess of the premiums permitted under this title;

(iii) acts to discriminate among individuals in violation of the provision of paragraph (2)(A)(v), including expulsion or refusal to re-enroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this subsection) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;[245]

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[242] P.L. 101-508, §4732(c), added subparagraph (H), effective November 5, 1990.

[243] P.L. 101-508. §4732(d)(2), struck out paragraph (3), effective November 5, 1990. Until then, paragraph (3) read as follows:

"(3) A State may, in the case of an entity which has submitted an application to the Secretary for determination that it is a health maintenance organization within the meaning of paragraph (1) and for which no such determination has been made within 90 days of the submission of the application, make a provisional determination for the purposes of this title that such entity is such a health maintenance organization. Such provisional determination shall remain in force until such time as the Secretary makes a determination regarding the entity's qualification under paragraph (1).".

[244] P.L. 78-410.

(iv) misrepresents or falsifies information that is furnished—

(I) to the Secretary or the State under this subsection, or

(II) to an individual or to any other entity under this subsection, or[246]

(v) fails to comply with the requirements of section 1876(i)(8),[247]

the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in subparagraph (B).

(B) The remedies described in this subparagraph are—

(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A), or, with respect to a determination under clause (iii) or (iv)(I) of such subparagraph, of not more than $100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iii), $15,000 for each individual not enrolled as a result of a practice described in such subparagraph, or

(ii) denial of payment to the State for medical assistance furnished under the contract under this subsection for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(6)(A) For purposes of this subsection and section 1902(e)(2)(A), in the case of the State of New Jersey, the term "contract" shall be deemed to include an undertaking by the State agency, in the State plan under this title, to operate a program meeting all requirements of this subsection.

(B) The undertaking described in subparagraph (A) must provide—

(i) for the establishment of a separate entity responsible for the operation of a program meeting the requirements of this subsection, which entity may be a subdivision of the State agency administering the State plan under this title;

(ii) for separate accounting for the funds used to operate such program;

(iii) for setting the capitation rates and any other payment rates for services provided in accordance with this subsection using a methodology satisfactory to the Secretary designed to ensure that total Federal matching payments under this title for such services will be lower than the matching payments that would be made for the same services, if provided under the State plan on a fee for service basis to an actuarially equivalent population; and

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[245] P.L. 101-508, §4731(b)(2)(A), struck out "or".

[246] P.L. 101-508, §4731(b)(2)(B), added "or".

[247] P.L. 101-508, §4731(b)(2)(C), added clause (v), applicable to contract years beginning on or after January 1, 1992.

(iv) that the State agency will contract, for purposes of meeting the requirement under section 1902(a)(30)(C), with an organization or entity that under section 1154 reviews services provided by an eligible organization pursuant to a contract under section 1876 for the purpose of determining whether the quality of services meets professionally recognized standards of health care.

(C) The undertaking described in subparagraph (A) shall be subject to approval (and annual re-approval) by the Secretary in the same manner as a contract under this subsection.

(D) The undertaking described in subparagraph (A) shall not be eligible for a waiver under section 1915(b).

[(n) Repealed. [248]**]**

(o) Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions of this section for expenditures for medical assistance provided for an individual under its State plan approved under this title to the extent that a private insurer (as defined by the Secretary by regulation) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.

(p)(1) When a political subdivision of a State makes, for the State of which it is a political subdivision, or one State makes, for another State, the enforcement and collection of rights of support or payment assigned under section 1912, pursuant to a cooperative arrangement under such section (either within or outside of such State), there shall be paid to such political subdivision or such other State from amounts which would otherwise represent the Federal share of payments for medical assistance provided to the eligible individuals on whose behalf such enforcement and collection was made, an amount equal to 15 percent of any amount collected which is attributable to such rights of support or payment.

(2) Where more than one jurisdiction is involved in such enforcement or collection, the amount of the incentive payment determined under paragraph (1) shall be allocated among the jurisdictions in a manner to be prescribed by the Secretary.

(q) For the purposes of this section, the term "State medicaid fraud control unit" means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

(1) The entity (A) is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations, (B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Secretary, that (i) assure its referral of suspected criminal violations relating to the program under this title to the appropriate authority or authorities in the State for prosecution and (ii)

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[248] P.L. 100-93, §8(h)(1); 101 Stat. 694.

assure its assistance of, and coordination with, such authority or authorities in such prosecutions, or (C) has a formal working relationship with the office of the State Attorney General and has formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Secretary and which provide effective coordination of activities between the entity and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the program under this title.

(2) The entity is separate and distinct from the single State agency that administers or supervises the administration of the State plan under this title.

(3) The entity's function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan under this title.

(4) The entity has procedures for reviewing complaints of the abuse and neglect of patients of health care facilities which receive payments under the State plan under this title, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other State agencies for action.

(5) The entity provides for the collection, or referral for collection to a single State agency, of overpayments that are made under the State plan to health care facilities and that are discovered by the entity in carrying out its activities.

(6) The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity's activities.

(7) The entity submits to the Secretary an application and annual reports containing such information as the Secretary determines, by regulation, to be necessary to determine whether the entity meets the other requirements of this subsection.

(r)(1)(A) In order to receive payments under paragraphs (2)(A)[249] and (7) of subsection (a) without being subject to per centum reductions set forth in subparagraph (C) of this paragraph, a State must provide that mechanized claims processing and information retrieval systems of the type described in subsection (a)(3)(B) and detailed in an advance planning document approved by the Secretary are operational on or before the deadline established under subparagraph (B).

(B) The deadline for operation of such systems for a State is September 30, 1985.

(C) If a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraphs (2)(A)[250] and (7) of subsection (a) with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning on or after such deadline, and shall be further reduced by an additional 5 percentage points after each period consisting of two quarters during which the Secretary determines the State fails to meet the requirements of subparagraph (A); except that—

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[249] P.L. 100-203, §4212(c)(2), inserted "(A)". For the effective date, see Vol. II, P.L. 100-203, §4214.

[250] P.L. 100-203, §4212(c)(2), inserted "(A)". For the effective date, see Vol. II, P.L. 100-203, §4214.

(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph; and

(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State meets the requirements of subparagraph (A).

(2)(A) In order to receive payments under paragraphs (2)(A)[251] and (7) of subsection (a) without being subject to the per centum reductions set forth in subparagraph (C) of this paragraph, a State must have its mechanized claims processing and information retrieval systems, of the type required to be operational under paragraph (1), initially approved by the Secretary in accordance with paragraph (5)(A) on or before the deadline established under subparagraph (B).

(B) The deadline for approval of such systems for a State is the last day of the fourth quarter that begins after the date on which the Secretary determines that such systems became operational as required under paragraph (1).

(C) If a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraphs (2)(A)[252] and (7) of subsection (a) with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning after such deadline, and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two quarters during which the State fails to meet the requirements of subparagraph (A); except that—

(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph, and

(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State's systems are approved by the Secretary as provided in subparagraph (A).

(D) Any State's systems which are approved by the Secretary for purposes of subsection (a)(3)(B) on or before the date of the enactment of this subsection[253] shall be deemed to be initially approved for purposes of this subsection.

(3)(A) When a State's systems are initially approved, the 75 per centum Federal matching provided in subsection (a)(3)(B) shall become effective with respect to such systems, retroactive to the first quarter beginning after the date on which such systems became operational as required under paragraph (1), except as provided in subparagraph (B).

(B) In the case of any State which was subject to a per centum reduction under paragraph (2), the per centum specified in subsection (a)(3)(B) shall be reduced by 5 percentage points for the first two quarters beginning after the deadline established under paragraph (2)(B), and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two quarters beginning after such deadline and before the date on which such systems are initially approved, except that no reduction shall be made under this paragraph for any quarter following the quarter during which the State's systems are initially approved by the Secretary.

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[251] P.L. 100-203, §4212(c)(2), inserted "(A)". For the effective date, see Vol. II, P.L. 100-203, §4214.

[252] P.L. 100-203, §4212(c)(2), inserted "(A)". For the effective date, see Vol. II, P.L. 100-203, §4214.

[253] October 7, 1980 [P.L. 96-398; 94 Stat. 1564, 1610].

(4)(A) The Secretary shall review all approved systems not less often than once every three years, and shall reapprove or disapprove any such systems. Systems which fail to meet the current performance standards, system requirements, and any other conditions for approval developed by the Secretary under paragraph (6) shall be disapproved. Any State having systems which are so disapproved shall be subject to a per centum reduction under subparagraph (B). The Secretary shall make the determination of reapproval or disapproval and so notify the States not later than the end of the first quarter following the review period. Reviews may, at the Secretary's discretion, constitute reviews of the entire system or of only those standards, systems requirements, and other conditions which have demonstrated weakness in previous reviews.

(B) If the Secretary disapproves a State's systems under subparagraph (A), the Secretary shall, with respect to such State for quarters beginning after the determination of disapproval and before the first quarter beginning after such systems are reapproved, reduce the per centum specified in subsection (a)(3)(B) to a per centum of not less than 50 per centum and not more than 70 per centum as the Secretary determines to be appropriate and commensurate with the nature of noncompliance by such State; except that such per centum may not be reduced by more than 10 percentage points in any 4-quarter period by reason of this subparagraph. No State shall be subject to a per centum reduction under this paragraph (i) before the fifth quarter beginning after such State's systems were initially approved, or (ii) on the basis of a review conducted before October 1, 1981.

(C) The Secretary may retroactively waive a per centum reduction imposed under subparagraph (B), if the Secretary determines that the State's systems meet all current performance standards and other requirements for reapproval and that such action would improve the administration of the State's plan under this title, except that no such waiver may extend beyond the four quarters immediately prior to the quarter in which the State's systems are reapproved.

(5)(A) In order to be initially approved by the Secretary, mechanized claims processing and information retrieval systems must be of the type described in subsection (a)(3)(B) and must meet the following requirements:

(i) The systems must be capable of developing provider, physician, and patient profiles which are sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

(ii) The State must provide that information on probable fraud or abuse which is obtained from, or developed by, the systems, is made available to the State's medicaid fraud control unit (if any) certified under subsection (q) of this section.

(iii) The systems must meet all performance standards and other requirements for initial approval developed by the Secretary under paragraph (6).

(B) In order to be reapproved by the Secretary, mechanized claims processing and information retrieval systems must meet the requirements of subparagraphs (A)(i) and (A)(ii) and performance standards and other requirements for reapproval developed by the Secretary under paragraph (6).

(6) The Secretary, with respect to State systems, shall—

(A) develop performance standards, system requirements, and other conditions for approval for use in initially approving such State systems, and shall further develop written approval procedures for conducting reviews for initial approval, including specific criteria for assessing systems in operation to insure that all such performance standards and other requirements are met;

(B) by not later than October 1, 1980, develop an initial set of performance standards, system requirements, and other conditions for reapproval for use in reapproving or disapproving State systems, and shall further develop written reapproval procedures for conducting reviews for reapproval, including specific criteria for reassessing systems operations over a period of at least six months during each fiscal year to insure that all such performance standards and other requirements are met on a continuous basis;

(C) provide that reviews for reapproval, conducted before October 1, 1981, shall be for the purpose of developing a systems performance data base and assisting States to improve their systems, and that no per centum reduction shall be made under paragraph (4) on the basis of such a review;

(D) insure that review procedures, performance standards, and other requirements developed under subparagraph (B) are sufficiently flexible to allow for differing administrative needs among the States, and that such procedures, standards, and requirements are of a nature which will permit their use by the States for self-evaluation;

(E) notify all States of proposed procedures, standards, and other requirements at least one quarter prior to the fiscal year in which such procedures, standards, and other requirements will be used for conducting reviews for reapproval;

(F) periodically update the systems performance standards, system requirements, review criteria, objectives, regulations, and guides as the Secretary shall from time to time deem appropriate;

(G) provide technical assistance to States in the development and improvement of the systems so as to continually improve the capacity of such systems to effectively detect cases of fraud or abuse;

(H) for the purpose of insuring compatibility between the State systems and the systems utilized in the administration of title XVIII—

(i) develop a uniform identification coding system (to the extent feasible) for providers, other persons receiving payments under the State plans (approved under this title) or under title XVIII, and beneficiaries of medical services under such plans or title;

(ii) provide liaison between States and carriers and intermediaries having agreements under title XVIII to facilitate timely exchange of appropriate data; and

(iii) improve the exchange of data between the States and the Secretary with respect to providers and other persons who have been terminated, suspended, or otherwise sanctioned under a State plan (approved under this title) or under title XVIII;

(I) develop and disseminate clear definitions of those types of reasonable costs relating to State systems which are reimbursable under the provisions of subsection (a)(3) of this section; and

(J) develop and disseminate performance standards for assessing the State's third party collection efforts in accordance with section 1902(a)(25)(A)(ii).

(7)(A) The Secretary shall waive the provisions of this subsection with respect to initial operation and approval of mechanized claims processing and information retrieval systems with respect to any State which—

(i) had a 1976 population (as reported by the Bureau of the Census) of less than 1,000,000 and which made total expenditures (including Federal reimbursement) for which Federal financial participation is authorized under this title of less than $100,000,000 in fiscal year 1976 (as reported by such State for such year), or

(ii) is a Commonwealth, or territory or possession, of the United States,

if such State reasonably demonstrates, and the Secretary does not formally disagree, that the application of such provisions would not significantly improve the efficiency of the administration of such State's plan under this title.

(B) If the Secretary determines that the application of the provisions described in subparagraph (A) to a State would significantly improve the efficiency of the administration of the State's plan under this title, the Secretary may withdraw the State's waiver under subparagraph (A) and, in such case, the Secretary shall impose a timetable for such State with respect to compliance with the provisions of this subsection and the imposition of per centum reductions. Such timetable shall be comparable to the timetable established under this subsection as to the amount of time allowed such State to comply and the timing of per centum reductions.

(8)(A) The per centum reductions provided for under this subsection shall not apply to a State for any quarter with respect to which the Secretary determines that such State is unable to comply with the relevant requirements of this subsection—

(i) for good cause (but such a waiver may not be for a period in excess of 2 quarters), or

(ii) due to circumstances beyond the control of such State.

(B) If the Secretary determines under subparagraph (A) that such a reduction will not apply to a State, the Secretary shall report to the Congress on the basis for each such determination and on the modification of all time limitations and deadlines as described in subparagraph (C).

(C) For purposes of determining all time limitations and deadlines imposed under this subsection, any time period during which a State was found under subparagraph (A)(ii) to be unable to comply with requirements of this subsection due to circumstances beyond its control shall not be taken into account, and the Secretary shall modify all such time limitations and deadlines with respect to such State accordingly.

[(s) Repealed.[254]**]**

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[254] P.L. 97-35, §2161(c)(1); 95 Stat. 805.

[(t) Repealed.[255]]

(u)(1)(A) Notwithstanding subsection (a)(1), if the ratio of a State's erroneous excess payments for medical assistance (as defined in subparagraph (D)) to its total expenditures for medical assistance under the State plan approved under this title exceeds 0.03, for the period consisting of the third and fourth quarters of fiscal year 1983, or for any full fiscal year thereafter, then the Secretary shall make no payment for such period or fiscal year with respect to so much of such erroneous excess payments as exceeds such allowable error rate of 0.03.

(B) The Secretary may waive, in certain limited cases, all or part of the reduction required under subparagraph (A) with respect to any State if such State is unable to reach the allowable error rate for a period or fiscal year despite a good faith effort by such State.

(C) In estimating the amount to be paid to a State under subsection (d), the Secretary shall take into consideration the limitation on Federal financial participation imposed by subparagraph (A) and shall reduce the estimate he makes under subsection (d)(1), for purposes of payment to the State under subsection (d)(3), in light of any expected erroneous excess payments for medical assistance (estimated in accordance with such criteria, including sampling procedures, as he may prescribe and subject to subsequent adjustment, if necessary, under subsection (d)(2)).

(D)(i) For purposes of this subsection, the term "erroneous excess payments for medical assistance" means the total of—

(I) payments under the State plan with respect to ineligible individuals and families, and

(II) overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility.

(ii) In determining the amount of erroneous excess payments for medical assistance to an ineligible individual or family under clause (i)(I), if such ineligibility is the result of an error in determining the amount of the resources of such individual or family, the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment with respect to such individual or family, or (II) the difference between the actual amount of such resources and the allowable resource level established under the State plan.

(iii) In determining the amount of erroneous excess payments for medical assistance to an individual or family under clause (i)(II), the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment on behalf of the individual or family, or (II) the difference between the actual amount incurred for medical care by the individual or family and the amount which should have been incurred in order to establish eligibility for medical assistance.

(iv) In determining the amount of erroneous excess payments, there shall not be included any error resulting from a failure of an individual to cooperate or give correct information with respect to third-party liability as required under section 1912(a)(1)(C) or

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[255] P.L. 97-35, §2161(c)(2); 95 Stat. 805.

402(a)(26)(C) or with respect to payments made in violation of section 1906[256].

(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1920(b)(1)).

(E) For purposes of subparagraph (D), there shall be excluded, in determining both erroneous excess payments for medical assistance and total expenditures for medical assistance—

(i) payments with respect to any individual whose eligibility therefor was determined exclusively by the Secretary under an agreement pursuant to section 1634 and such other classes of individuals as the Secretary may by regulation prescribe whose eligibility was determined in part under such an agreement; and

(ii) payments made as the result of a technical error.[257]

(2) The State agency administering the plan approved under this title shall, at such times and in such form as the Secretary may specify, provide information on the rates of erroneous excess payments made (or expected, with respect to future periods specified by the Secretary) in connection with its administration of such plan, together with any other data he requests that are reasonably necessary for him to carry out the provisions of this subsection.

(3)(A) If a State fails to cooperate with the Secretary in providing information necessary to carry out this subsection, the Secretary, directly or through contractual or such other arrangements as he may find appropriate, shall establish the error rates for that State on the basis of the best data reasonably available to him and in accordance with such techniques for sampling and estimating as he finds appropriate.

(B) In any case in which it is necessary for the Secretary to exercise his authority under subparagraph (A) to determine a State's error rates for a fiscal year, the amount that would otherwise be payable to such State under this title for quarters in such year shall be reduced by the costs incurred by the Secretary in making (directly or otherwise) such determination.

(4) This subsection shall not apply with respect to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, or American Samoa.[258]

(v)(1) Notwithstanding the preceding provisions of this section, except as provided in paragraph (2), no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

(2) Payment shall be made under this section for care and services that are furnished to an alien described in paragraph (1) only if—

(A) such care and services are necessary for the treatment of an emergency medical condition of the alien, and

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[256] P.L. 101-508, §4402(b), inserted "or with respect to payments made in violation of section 1906", at the end of "Section 1903(u)(1)(C)(iv)". For the effective date, see Vol. II, P.L. 101-508, §4402(e). Executed as if §4402(b) read "Section 1903(u)(1)(D)(iv)".

[257] See Vol. II, P.L. 100-203, §4118(n), with respect to the temporary definition of technical error.

[258] See Vol. II, P.L. 100-203, §4117, with respect to the delay in quality control sanctions for Medicaid.

See Vol. II, P.L. 100-485, §608(h), with respect to the quality control transition.

See Vol. II, P.L. 101-508, §4607(b), with respect to the transition on errors in eligibility determinations.

(B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this title (other than the requirement of the receipt of aid or assistance under title IV, supplemental security income benefits under title XVI, or a State supplementary payment).

(3) For purposes of this subsection, the term "emergency medical condition" means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(A) placing the patient's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

OPERATION OF STATE PLANS[259]

SEC. 1904. [42 U.S.C. 1396c] If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1902; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

DEFINITIONS [260]

SEC. 1905. [42 U.S.C. 1396d] For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are—

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[259] See Vol. II, P.L. 101-508, §4801(a)(1), with respect to nurse aide training and competency evaluation, and §4801(c), with respect to enforcement process.

[260] See Vol. II, P.L. 101-508, §4720, with respect to personal care services for Minnesota.

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

(ii) relatives specified in section 406(b)(1) with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of title IV,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under title XVI,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI,

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title XVI,

(viii) pregnant women,[261]

(ix) individuals provided extended benefits under section 1925, or[262]

(x) individuals described in section 1902(u)(1),[263]

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for mental diseases);

(2)(A) outpatient hospital services,[264] (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1)[265]) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1)[266]) and which are otherwise included in the plan[267], and (C) Federally-qualified health center services (as defined in subsection (l)(2)) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan[268];

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[261] P.L. 101-508, §4713(b)(1), struck out "or".

[262] P.L. 100-485, §303(b)(2), added clause (ix), applicable to payments under this title for calendar quarters beginning on or after April 1, 1990 (or, in the case of the Commonwealth of Kentucky, October 1, 1990) (without regard to whether regulations to implement this amendment are promulgated by such date), with respect to families that cease to be eligible for aid under part A of title IV on or after such date.

P.L. 101-508, §4713(b)(2), added "or".

[263] P.L. 101-508, §4713(b)(3), added clause (x), applicable to medical assistance furnished on or after January 1, 1991.

[264] P.L. 101-239, §6402(c)(1), struck out "and".

P.L. 101-239, §6404(a)(l), made the same amendment.

P.L. 101-508, §4704(e), struck out P.L. 101-239, §6402(c)(1), effective as if included in the enactment of P.L. 101-239.

[265] P.L. 101-239, §6404(a)(2), struck out "(l)" and substituted "(l)(1)". For the effective date, see Vol. II, P.L. 101-239, §6404(d).

[266] P.L. 101-239, §6404(a)(2), struck out "(l)" and substituted "(l)(1)". For the effective date, see Vol. II, P.L. 101-239, §6404(d).

[267] P.L. 101-239, §6402(c)(1), inserted ", and (C) ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age" and §6402(d)(2) read as follows:

"(2)(A) The amendments made by subsection (c) apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (c), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.".

(3) other laboratory and X-ray services;

(4)(A)[269] nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for individuals who are eligible under the plan and are under the age of 21; and[270] (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

(5)(A) physicians' services furnished by a physician (as defined in section 1861(r)(1)), whether furnished in the office, the patient's home, a hospital, or a[271] nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist (described in section 1861(r)(2)) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section 1861(r)(1));

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services including personal care services (A) prescribed by a physician for an individual in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, (C) supervised by a registered nurse, and (D) furnished in a home or other location; but not including such services furnished to an inpatient or resident of a nursing facility[272];

(8) private duty nursing services;

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

P.L. 101-508, §4704(e), in effect, struck out ", and" and subparagraph (C), effective as if included in the enactment of P.L. 101-239, and revised and redesignated P.L. 101-239, §6402(d).

[268] P.L. 101-239, §6404(a)(3), inserted ", and" and this second subparagraph (C). For the effective date, see Vol. II, P.L. 101-239, §6404(d).

[269] P.L. 100-203, §4211(f), struck out "skilled". For the effective date, see Vol. II, P.L. 100-203, §4214.

[270] P.L. 101-239, §6403(d)(2), amended subparagraph (B) in its entirety, effective April 1, 1990, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date. [For subparagraph (B) as if formerly read, see Vol. III, P.L. 101-239.]

[271] P.L. 100-203, §4211(h)(6)(A), struck out "skilled". For the effective date, see Vol. II, P.L. 100-203, §4214.

[272] P.L. 101-508, §4721(a), inserted "including personal care services (A) prescribed by a physician for an individual in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, (C) supervised by a registered nurse, and (D) furnished in a home or other location; but not including such services furnished to an inpatient or resident of a nursing facility", effective with respect to personal care services provided on or after October 1, 1994.

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level[273];

(14) inpatient hospital services and nursing[274] facility services for individuals 65 years of age or over in an institution for mental diseases;

(15) services in an intermediate care facility for the mentally retarded (other than[275] in an institution for mental diseases) for individuals who are determined, in accordance with section 1902(a)(31)(A), to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h);

(17) services furnished by a nurse-midwife (as defined in section 1861(gg)) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider;

(18) hospice care (as defined in subsection (o));

(19) case-management services (as defined in section 1915(g)(2));

(20) respiratory care services (as defined in section 1902(e)(9)(C));[276]

(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider; and[277]

(22)[278] any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;[279]

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[273] P.L. 101-508, §4719(a), inserted ", including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level", effective November 5, 1990.

[274] P.L. 100-203, §4211(h)(6)(B), struck out ", skilled nursing facility services, and intermediate care" and substituted "and nursing". For the effective date, see Vol. II, P.L. 100-203, §4214.

[275] P.L. 100-203, §4211(h)(6)(C), struck out "intermediate care facility services (other than such services" and substituted "services in an intermediate care facility for the mentally retarded (other than". For the effective date, see Vol. II, P.L. 100-203, §4214.

[276] P.L. 101-239, §6405(a)(1), struck out "and".

[277] P.L. 101-239, §6405(a)(3), added this paragraph (21), effective with respect to services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner on or after July 1, 1990.

[278] P.L. 101-239, §6405(a)(2), redesignated paragraph (21) as paragraph (22).

[279] P.L. 101-508, §4711(a)(1), struck out "and". Impossible to execute.

(23) home and community care (to the extent allowed and as defined in section 1929) for functionally disabled elderly individuals;[280]

(24) community supported living arrangements services (to the extent allowed and as defined in section 1930).[281]

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under title I, X, XIV, or XVI), and such person is determined, under such a State plan, to be essential to the well-being of such individual. The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of title XVIII for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under title XVIII who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof.[282] No service (including counseling) shall be excluded from the definition of "medical assistance" solely because it is provided as a treatment service for alcoholism or drug dependency.[283]

(b) The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act[284]).

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[280] P.L. 101-508, §4711(a)(2), redesignated "paragraph (23)" as "paragraph (24)". Impossible to execute; no former paragraph (23).

P.L. 101-508, §4711(a)(3), added paragraph (23), applicable to home and community care furnished on or after July 1, 1991, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

P.L. 101-508, §4712(a)(1), struck out "and".

[281] P.L. 101-508, §4712(a)(2), redesignated "paragraph (24)" as "paragraph (25)". Impossible to execute; no former paragraph (24).

P.L. 101-508, §4712(a)(3), added paragraph (24), applicable to community supported living arrangements services furnished on or after July 1, 1991, or 30 days after the publication of regulations setting forth interim requirements under subsection (h) without regard to whether or not final regulations to carry out this amendment have been promulgated by such date. The Secretary shall provide that the applications required to be submitted by States under P.L. 101-508, §4712, shall be received and approved prior to the effective date specified in the preceding sentence.

[282] P.L. 101-508, §4402(d)(2), added this sentence. For the effective date, see Vol. II, P.L. 101-508, §4402(e).

[283] P.L. 101-508, §4722, added this sentence, effective November 5, 1990.

(c) For definition of the term "nursing facility", see section 1919(a).[285]

(d) The term "intermediate care facility for the mentally retarded[286]" means an[287] institution (or distinct part thereof) for the mentally retarded or persons with related conditions if—

(1) the primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and the institution meets such standards as may be prescribed by the Secretary;

(2) the mentally retarded individual with respect to whom a request for payment is made under a plan approved under this title is receiving active treatment under such a program; and

(3) in the case of a public institution,[288] the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institution (or distinct part thereof) in the State will not, because of payments made under this title, be reduced below the average amount expended for such services in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under this title.

(e) In the case of any State the State plan of which (as approved under this title)—

(1) does not provide for the payment of services (other than services covered under section 1902(a)(12)) provided by an optometrist; but

(2) at a prior period did provide for the payment of services referred to in paragraph (1);

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[284] P.L. 94-437.

[285] P.L. 100-203, §4211(e)(sic)(1), amended subsection (c) in its entirety. For the effective date, see Vol. II, P.L. 100-203, §4214. [For subsection (c) as it formerly read, see Vol. III, P.L. 100-203.]

P.L. 100-360, §411(l)(3)(C)(i) [as redesignated by P.L. 100-485, §608(d)(27)(E)], provides that effective July 1, 1988, and until the effective date of §1919(c), this subsection is deemed to include the requirement described in §1919(c)(3)(A).

[286] P.L. 100-203, §4211(e)(sic)(2)(A), struck out "services" and substituted "for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[287] P.L. 100-203, §4211(e)(sic)(2)(B), struck out "may include services in a public" and substituted "means an". For the effective date, see Vol. II, P.L. 100-203, §4214.

[288] P.L. 100-203, §4211(e)(sic)(2)(C), inserted "in the case of a public institution,". For the effective date, see Vol. II, P.L. 100-203, §4214.

the term "physicians' services" (as used in subsection (a)(5)) shall include services of the type which an optometrist is legally authorized to perform where the State plan specifically provides that the term "physicians' services", as employed in such plan, includes services of the type which an optometrist is legally authorized to perform, and shall be reimbursed whether furnished by a physician or an optometrist.

(f) For purposes of this title, the term "[289] nursing facility services" means services which are or were required to be given an individual who needs or needed on a daily basis[290] nursing care (provided directly by or requiring the supervision of [291] nursing personnel) or other[292] rehabilitation services which as a practical matter can only be provided in a[293] nursing facility on an inpatient basis.

(g) If the State plan includes provision of chiropractors' services, such services include only—

(1) services provided by a chiropractor (A) who is licensed as such by the State and (B) who meets uniform minimum standards promulgated by the Secretary under section 1861(r)(5); and

(2) services which consist of treatment by means of manual manipulation of the spine which the chiropractor is legally authorized to perform by the State.

(h)(1) For purposes of paragraph (16) of subsection (a), the term "inpatient psychiatric hospital services for individuals under age 21" includes only—

(A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1861(f) or in another inpatient setting that the Secretary has specified in regulations[294];

(B) inpatient services which, in the case of any individual (i) involve active treatment which meets such standards as may be prescribed in regulations by the Secretary, and (ii) a team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary; and

(C) inpatient services which, in the case of any individual, are provided prior to (i) the date such individual attains age 21, or (ii) in the case of an individual who was receiving such services in the period immediately preceding the date on which he attained age 21, (I) the date such individual no longer requires such services, or (II) if earlier, the date such individual attains age 22;

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[289] P.L. 100-203, §4211(e)(sic)(3), struck out "skilled". For the effective date, see Vol. II, P.L. 100-203, §4214.

[290] P.L. 100-203, §4211(e)(sic)(3), struck out "skilled". For the effective date, see Vol. II, P.L. 100-203, §4214.

[291] P.L. 100-203, §4211(e)(sic)(3), struck out "skilled". For the effective date, see Vol. II, P.L. 100-203, §4214.

[292] P.L. 100-203, §4211(e)(sic)(3), struck out "skilled". For the effective date, see Vol. II, P.L. 100-203, §4214.

[293] P.L. 100-203, §4211(e)(sic)(3), struck out "skilled". For the effective date, see Vol. II, P.L. 100-203, §4214.

[294] P.L. 101-508, §4755(a)(1)(A), inserted "or in another inpatient setting that the Secretary has specified in regulations", effective as if included in the enactment of P.L. 98-369.

(2) Such term does not include services provided during any calendar quarter under the State plan of any State if the total amount of the funds expended, during such quarter, by the State (and the political subdivisions thereof) from non-Federal funds for inpatient services included under paragraph (1), and for active psychiatric care and treatment provided on an outpatient basis for eligible mentally ill children, is less than the average quarterly amount of the funds expended, during the 4-quarter period ending December 31, 1971, by the State (and the political subdivisions thereof) from non-Federal funds for such services.

(i) The term "institution for mental diseases" means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.[295]

(j) The term "State supplementary payment" means any cash payment made by a State on a regular basis to an individual who is receiving supplemental security income benefits under title XVI or who would but for his income be eligible to receive such benefits, as assistance based on need in supplementation of such benefits (as determined by the Secretary), but only to the extent that such payments are made with respect to an individual with respect to whom supplemental security income benefits are payable under title XVI, or would but for his income be payable under that title.

(k) Increased supplemental security income benefits payable pursuant to section 211 of Public Law 93-66 shall not be considered supplemental security income benefits payable under title XVI.

(l)(1)[296] The terms "rural health clinic services" and "rural health clinic" have the meanings given such terms in section 1861(aa), except that (A)[297] clause (ii) of section 1861(aa)(2) shall not apply to such terms, and (B)[298] the physician arrangement required under section 1861(aa)(2)(B) shall only apply with respect to rural health clinic services and, with respect to other ambulatory care services, the physician arrangement required shall be only such as may be required under the State plan for those services.

(2)(A) The term "Federally-qualififed health center services" means services of the type described in subparagraphs (A) through (C) of section 1861(aa)(1) when furnished to an individual as an patient[299] of a Federally-qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in section 1861(aa)(2)(B) is deemed a reference to a Federally-qualified health center or a physician at the center, respectively.

(B) The term "Federally-qualified health center" means a entity[300] which—

(i) is receiving a grant under section 329, 330, or 340 of the Public Health Service Act[301], or

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[295] P.L. 100-203, §4211(e)(sic)(4), struck out subsection (i). For the effective date, see Vol. II, P.L. 100-203, §4214.

P.L. 100-360, §411(k)(14)(A), added this subsection (i), effective July 1, 1988.

[296] P.L. 101-239, §6404(b)(2), inserted "(1)".

[297] P.L. 101-239, §6404(b)(1), redesignated paragraph (1) as subparagraph (A).

[298] P.L. 101-239, §6404(b)(1), redesignated paragraph (2) as subparagraph (B).

[299] P.L. 101-508, §4704(c)(1), struck out "outpatient" and substituted "patient", effective as if included in the enactment of P.L. 101-239. Should read "a patient".

[300] P.L. 101-508, §4707(c)(2), struck out "facility" and substituted "entity", effective as if included in the enactment of P.L. 239. As in original. Should read "an entity".

[301] P.L. 78-410.

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and

(II) meets the requirements to receive a grant under section 329, 330, or 340 of such Act;[302]

(iii)[303] based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant,[304]

and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638).[305] In applying clause (ii), the Secretary may waive any requirement referred to in such clause for up to 2 years for good cause shown.[306]

(m)(1) Subject to paragraph (2), the term "qualified family member" means an individual (other than a qualified pregnant woman or child, as defined in subsection (n)) who is a member of a family that would be receiving aid under the State plan under part A of title IV pursuant to section 407 if the State had not exercised the option under section 407(b)(2)(B)(i).

(2) No individual shall be a qualified family member for any period after September 30, 1998.[307]

(n) The term "qualified pregnant woman or child" means—

(1) a pregnant woman who—

(A) would be eligible for aid to families with dependent children under part A of title IV (or would be eligible for such aid if coverage under the State plan under part A of title IV included aid to families with dependent children of unemployed parents pursuant to section 407) if her child had been born and was living with her in the month such aid would be paid, and such pregnancy has been medically verified;

(B) is a member of a family which would be eligible for aid under the State plan under part A of title IV pursuant to section 407 if the plan required the payment of aid pursuant to such section; or

(C) otherwise meets the income and resources requirements of a State plan under part A of title IV; and

(2) a child who has not attained the age of 19[308], who was born after September 30, 1983 (or such earlier date as the State may designate), and who meets the income and resources requirements of the State plan under part A of title IV.

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[302] P.L. 101-508, §4704(c)(3), added clause (ii), effective as if included in the enactment of P.L. 101-239. Executed as if (c)(3) read "in subparagraph (B)". Margin as in original.

[303] P.L. 101-508, §4704(c)(3), redesignated clause (ii) as clause (iii), effective as if included in the enactment of P.L. 101-239.

[304] P.L. 101-508, §4704(d)(1), struck out a period and substitued a comma.

[305] P.L. 101-508, §4704(d)(2), added "and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638).", "after and below clause (ii)", effective as if included in the enactment of P.L. 101-239. Executed as if amendment read "after and below clause (iii)".

[306] P.L. 101-239, §6404(b)(3), added this paragraph (2). For the effective date, see Vol. II, P.L. 101-239, §6404(d).

[307] P.L. 100-485, §401(d)(2), added this subsection (m), effective October 1, 1990, except as provided in §1905(m)(2). With respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, this amendment shall become effective October 1, 1992.

[308] P.L. 101-508, §4601(a)(2), struck out "age of 7 (or any age designated by the State that exceeds 7 but does not exceed 8)" and substituted "age of 19". For the effective date, see Vol. II, P.L. 101-508, §4601(b)

(o)(1)(A) Subject to subparagraph (B), the term "hospice care" means the care described in section 1861(dd)(1) furnished by a hospice program (as defined in section 1861(dd)(2)) to a terminally ill individual who has voluntarily elected (in accordance with paragraph (2)) to have payment made for hospice care instead of having payment made for certain benefits described in section 1812(d)(2)(A) and for which payment may otherwise be made under title XVIII[309] and intermediate care facility services under the plan. For purposes of such election, hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care.

(B) For purposes of this title, with respect to the definition of hospice program under section 1861(dd)(2), the Secretary may allow an agency or organization to make the assurance under subparagraph (A)(iii) of such section without taking into account any individual who is afflicted with acquired immune deficiency syndrome (AIDS).

(2) An individual's voluntary election under this subsection —

(A) shall be made in accordance with procedures that are established by the State and that are consistent with the procedures established under section 1812(d)(2);

(B) shall be for such a period or periods (which need not be the same periods described in section 1812(d)(1)) as the State may establish; and

(C) may be revoked at any time without a showing of cause and may be modified so as to change the hospice program with respect to which a previous election was made.

(3) In the case of[310] an individual —

(A) who is residing in a nursing facility or intermediate care facility for the mentally retarded[311] and is receiving medical assistance for services in such facility under the plan,

(B) who is entitled to benefits under part A of title XVIII and has elected, under section 1812(d), to receive hospice care under such part, and

(C) with respect to whom the hospice program under such title and the nursing facility or intermediate care facility for the mentally retarded[312] have entered into a written agreement under which the program takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual,

instead of any payment otherwise made under the plan with respect to the facility's services, the State shall provide for payment to the hospice program of an amount equal to the additional amount described in section 1902(a)(13)(D)[313] and, if the individual is an individual described in section 1902(a)(10)(A), shall provide for payment of any coinsurance amounts imposed under section 1813(a)(4).[314]

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[309] P.L. 101-508, §4717, inserted "and for which payment may otherwise be made under title XVIII", effective November 5, 1990.

[310] P.L. 101-508, §4705(a)(1), struck out "a State which elects not to provide medical assistance for hospice care, but provides medical assistance for skilled nursing or intermediate care facility services with respect to", effective as if included in the amendments made by section 6408(c)(1) of P.L. 101-239.

[311] P.L. 101-508, §4705(a)(2), struck out "skilled nursing or intermediate care facility" and substituted "nursing facility or intermediate care facility for the mentally retarded", effective as if included in the amendments made by section 6408(c)(1) of P.L. 101-239.

[312] P.L. 101-508, §4705(a)(2), struck out "skilled nursing or intermediate care facility" and substituted "nursing facility or intermediate care facility for the mentally retarded", effective as if included in the amendments made by section 6408(c)(1) of P.L. 101-239.

(p)(1) The term "qualified medicare beneficiary" means an individual—

(A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1818A[315]),

(B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in paragraph (2)(D)[316]) does not exceed an income level established by the State consistent with paragraph (2), and

(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice[317] the maximum amount of resources that an individual may have and obtain benefits under that program.

(2)(A) The income level established under paragraph (1)(B) shall be at least the percent provided under subparagraph (B) (but[318] not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981[319]) applicable to a family of the size involved.

(B) Except as provided in subparagraph (C), the percent provided under this clause, with respect to eligibility for medical assistance on or after—

(i) January 1, 1989, is 85 percent,

(ii) January 1, 1990, is 90 percent, and[320]

(iii) January 1, 1991, is 100 percent.[321] [322]

(C) In the case of a State which has elected treatment under section 1902(f) and which, as of January 1, 1987, used an income standard for individuals age 65 or older which was more restrictive than the income standard established under the supplemental security income program under title XVI, the percent provided under subparagraph (B), with respect to eligibility for medical assistance on or after—

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[313] P.L. 101-508, §4705(a)(3), struck out "the amounts allocated under the plan for room and board in the facility, in accordance with the rates established under section 1902(a)(13)," and substituted "the additional amount described in section 1902(a)(13)(D)", effective as if included in the amendments made by §6408(c)(1) of P.L. 101-239.

[314] P.L. 101-508, §4705(a)(4), struck out "For purposes of this paragraph and section 1902(a)(13)(D), the term 'room and board' includes performance of personal care services, including assistance in activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.", effective as if included in the amendments made by §6408(c)(1) of P.L. 101-239.

[315] P.L. 101-239, §6408(d)(4)(B), inserted ", but not including an individual entitled to such benefits only pursuant to an enrollment under section 1818A". For the effective date, see Vol. II, P.L. 101-239, §6408(d)(5).

[316] P.L. 101-508, §4501(e)(1)(A), inserted ", except as provided in paragraph (2)(D)", applicable to determinations of income for months beginning with January 1991.

[317] P.L. 100-360, §301(c)(2), struck out "(except as provided in paragraph (2)(B))" and substituted "twice". For the effective date, see Vol. II, P.L. 100-360, §301(h).

[318] P.L. 100-360, §301(b)(1) [as amended by P.L. 100-485, §608(d)(14)(A)], struck out "may not exceed a percentage (" and substituted "shall be at least the percent provided under subparagraph (B) (but". For the effective date, see Vol. II, P.L. 100-360, §301(h).

[319] P.L. 97-35.

[320] P.L. 101-508, §4501(a)(1)(A), added "and".

[321] P.L. 101-508, §4501(a)(1)(B), struck out "95 percent, and" and substituted "100 percent.", applicable to calendar quarters beginning on or after January 1, 1991, without regard to whether or not regulations to implement such amendment are promulgated by such date.

[322] P.L. 101-508, §4501(a)(1)(C), struck out "(iv) January 1, 1992, is 100 percent.", applicable to calendar quarters beginning on or after January 1, 1991, without regard to whether or not regulations to implement such amendment are promulgated by such date.

(i) January 1, 1989, is 80 percent,

(ii) January 1, 1990, is 85 percent,

(iii) January 1, 1991, is 95[323] percent, and[324]

(iv) January 1, 1992, is 100 percent.[325] [326]

(D)(i) In determining under this subsection the income of an individual who is entitled to monthly insurance benefits under title II for a transition month (as defined in clause (ii)) in a year, such income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such title which have occurred pursuant to section 215(i) for benefits payable for months beginning with December of the previous year.

(ii) For purposes of clause (i), the term "transition month" means each month in a year through the month following the month in which the annual revision of the official poverty line, referred to in subparagraph (A), is published.[327]

(3) The term "medicare cost-sharing" means the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1818 or 1818A[328], and

(ii) premiums under section 1839,[329]

(B) Coinsurance under title XVIII (including coinsurance described in section 1813).[330]

(C) Deductibles[331] established under title XVIII (including those described in section 1813 and section 1833(b)[332]).[333]

(D) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent".

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1876.

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[323] P.L. 101-508, §4501(a)(2)(A), struck out "90" and substituted "95", applicable to calendar quarters beginning on or after January 1, 1991, without regard to whether or not regulations to implement such amendment are promulgated by such date.

[324] P.L. 101-508, §4501(a)(2)(B), added "and".

[325] P.L. 101-508, §4501(a)(2)(C), struck out "95 percent, and" and substituted "100 percent.", applicable to calendar quarters beginning on or after January 1, 1991, without regard to whether or not regulations to implement such amendment are promulgated by such date.

[326] P.L. 101-508, §4501(a)(2)(D), struck out "(v) January 1, 1993, is 100 percent.", applicable to calendar quarters beginning on or after January 1, 1991, without regard to whether or not regulations to implement such amendment are promulgated by such date.

[327] P.L. 101-508, §4501(e)(1)(B), added subparagraph (D), applicable to determinations of income for months beginning with January 1991.

[328] P.L. 101-239, §6408(d)(4)(A)(ii), inserted "or 1818A". For the effective date, see Vol. II, P.L. 101-239, §6408(d)(5).

[329] P.L. 101-239, §6408(d)(4)(A)(i), amended subparagraph (A) in its entirety. For the effective date, see Vol. II, P.L. 101-239, §6408(d)(5). [For subparagraph (A) as it formerly read, see Vol. III, P.L. 101-239.]

[330] P.L. 100-360, §301(d)(3) [as redesignated by P.L. 100-485, §608(d)(14)(G)(i)], amended subparagraphs (B) and (C) in their entirety. For the effective date, see Vol. II, P.L. 100-360, §301(h).

[331] P.L. 101-234, §201(b)(1)(A), struck out "Subject to paragraph (4), deductibles" and substituted "Deductibles", effective January 1, 1990.

[332] P.L. 101-234, §201(b)(1)(B), struck out ", section 1833(b), and section 1834(c)(1)" and substituted "and section 1833(b)", effective January 1, 1990.

[333] P.L. 100-360, §301(d)(3) [as redesignated by P.L. 100-485, §608(d)(14)(G)(i)], amended subparagraphs (B) and (C) in their entirety. For the effective date, see Vol. II, P.L. 100-360, §301(h).

(4)[334] Notwithstanding any other provision of this title, in the case of a State (other than the 50 States and the District of Columbia)—

(A) the requirement stated in section 1902(a)(10)(E) shall be optional, and

(B) for purposes of paragraph (2), the State may substitute for the percent provided under subparagraph (B) of such paragraph or 1902(a)(10)(E)(iii)[335] any percent.[336]

In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirement of section 1902(a)(10)(E) in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.[337]

(q) The term "qualified severely impaired individual" means an individual under age 65—

(1) who for the month preceding the first month to which this subsection applies to such individual—

(A) received (i) a payment of supplemental security income benefits under section 1611(b) on the basis of blindness or disability, (ii) a supplementary payment under section 1616 of this Act or under section 212 of Public Law 93-66 on such basis, (iii) a payment of monthly benefits under section 1619(a), or (iv) a supplementary payment under section 1616(c)(3), and

(B) was eligible for medical assistance under the State plan approved under this title; and

(2) with respect to whom the Secretary determines that—

(A) the individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, continues to meet all non-disability-related requirements for eligibility for benefits under title XVI,

(B) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611(b) (if he were otherwise eligible for such payments),

(C) the lack of eligibility for benefits under this title would seriously inhibit his ability to continue or obtain employment, and

(D) the individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under title XVI (including any federally administered State supplementary payments), this title, and publicly funded attendant care services (including personal care assistance) that would be available to him in the absence of such earnings.

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[334] P.L. 101-234, §201(b)(2), struck out paragraph (4) and redesignated paragraph (5) as paragraph (4), effective January 1, 1990. [For paragraph (4) as it formerly read, see Vol. III, P.L. 101-234.]

[335] P.L. 101-508, §4501(c)(1), inserted "or 1902(a)(10)(E)(iii)", applicable to calendar quarters beginning on or after January 1, 1991, without regard to whether or not regulations to implement such amendment are promulgated by such date. Executed as if amendment read "after 'subparagraph (B) of such paragraph' ".

[336] P.L. 100-360, §301(g)(2), added paragraph (5). For the effective date, see Vol. II, P.L. 100-360, §301(h).

[337] P.L. 101-508, §4501(c)(2), added this sentence, applicable to calendar quarters beginning on or after January 1, 1991, without regard to whether or not regulations to implement such amendment are promulgated by such date.

In the case of an individual who is eligible for medical assistance pursuant to section 1619(b) in June, 1987, the individual shall be a qualified severely impaired individual for so long as such individual meets the requirements of paragraph (2).

(r) The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:

(1) Screening services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

(B) which shall at a minimum include—

(i) a comprehensive health and developmental history (including assessment of both physical and mental health development),

(ii) a comprehensive unclothed physical exam,

(iii) appropriate immunizations according to age and health history,

(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and

(v) health education (including anticipatory guidance).

(2) Vision services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) Dental services—

(A) which are provided—

(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) Hearing services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

(5) Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this title shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services.[338] The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this title in early and periodic screening, diagnostic, and treatment services.[339]

(s) The term "qualified disabled and working individual" means an individual—

(1) who is entitled to enroll for hospital insurance benefits under part A of title XVIII under section 1818A (as added by 6012 of the Omnibus Budget Reconciliation Act of 1989[340]);

(2) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed 200 percent of the official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981[341]) applicable to a family of the size involved;

(3) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual or a couple (in the case of an individual with a spouse) may have and obtain benefits for supplemental security income benefits under title XVI; and

(4) who is not otherwise eligible for medical assistance under this title.[342]

ENROLLMENT OF INDIVIDUALS UNDER GROUP HEALTH PLANS[343]

SEC. 1906. [42 U.S.C. 1396e] (a) For purposes of section 1902(a)(25)(G) and subject to subsection (d), each State plan—

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[338] P.L. 101-239, §6403(a), added subsection (r), effective April 1, 1990, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

[339] P.L. 101-239, §6403(c), added this sentence, effective April 1, 1990, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

[340] P.L. 101-239.

[341] P.L. 97-35.

[342] P.L. 101-239, §6408(d)(2), added subsection (s). For the effective date, see Vol. II, P.L. 101-239, §6408(d)(5).

[343] P.L. 101-508, §4402(a)(2), added this §1906. For the effective date, see Vol. II, P.L. 101-508, §4402(e).

(1) shall implement guidelines established by the Secretary, consistent with subsection (b), to identify those cases in which enrollment of an individual otherwise entitled to medical assistance under this title in a group health plan (in which the individual is otherwise eligible to be enrolled) is cost-effective (as defined in subsection (e)(2));

(2) shall require, in case of an individual so identified and as a condition of the individual being or remaining eligible for medical assistance under this title and subject to subsection (b)(2), notwithstanding any other provision of this title, that the individual (or in the case of a child, the child's parent) apply for enrollment in the group health plan; and

(3) in the case of such enrollment (except as provided in subsection (c)(1)(B)), shall provide for payment of all enrollee premiums for such enrollment and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this title (exceeding the amount otherwise permitted under section 1916), and shall treat coverage under the group health plan as a third party liability (under section 1902(a)(25)).

(b)(1) In establishing guidelines under subsection (a)(1), the Secretary shall take into account that an individual may only be eligible to enroll in group health plans at limited times and only if other individuals (not entitled to medical assistance under the plan) are also enrolled in the plan simultaneously.

(2) If a parent of a child fails to enroll the child in a group health plan in accordance with subsection (a)(2), such failure shall not affect the child's eligibility for benefits under this title.

(c)(1)(A) In the case of payments of premiums, deductibles, coinsurance, and other cost-sharing obligations under this section shall be considered, for purposes of section 1903(a), to be payments for medical assistance.

(B) If all members of a family are not eligible for medical assistance under this title and enrollment of the members so eligible in a group health plan is not possible without also enrolling members not so eligible—

(i) payment of premiums for enrollment of such other members shall be treated as payments for medical assistance for eligible individuals, if it would be cost-effective (taking into account payment of all such premiums), but

(ii) payment of deductibles, coinsurance, and other cost-sharing obligations for such other members shall not be treated as payments for medical assistance for eligible individuals.

(2) The fact that an individual is enrolled in a group health plan under this section shall not change the individual's eligibility for benefits under the State plan, except insofar as section 1902(a)(25) provides that payment for such benefits shall first be made by such plan.

(d)(1) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

(2) This section, and section 1902(a)(25)(G), shall only apply to a State that is one of the 50 States or the District of Columbia.

(e) In this section:

(1) The term "group health plan" has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, and includes the provision of continuation coverage by such a plan pursuant to title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974.

(2) The term "cost-effective" means, as established by the Secretary, that the reduction in expenditures under this title with respect to an individual who is enrolled in a group health plan is likely to be greater than the additional expenditures for premiums and cost-sharing required under this section with respect to such enrollment.

OBSERVANCE OF RELIGIOUS BELIEFS

SEC. 1907. [42 U.S.C. 1396f] Nothing in this title shall be construed to require any State which has a plan approved under this title to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under such plan for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health), if such person objects (or, in case such person is a child, his parent or guardian objects) thereto on religious grounds.

[SEC. 1908. Repealed.[344]]

[SEC. 1909. Redesignated.[345]]

CERTIFICATION AND APPROVAL OF[346] OF RURAL HEALTH CLINICS AND INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED[347]

SEC. 1910. [42 U.S.C. 1396i] (a)[348](1) Whenever the Secretary certifies a facility in a State to be qualified as a rural health clinic under title XVIII, such facility shall be deemed to meet the standards for certification as a rural health clinic for purposes of providing rural health clinic services under this title.

(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any facility in that State which has applied for certification by him as a qualified rural health clinic.

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[344] P.L. 101-508, §4801(e)(11)(B), repealed §1908, effective on the date on which the Secretary promulgates standards regarding the qualifications of nursing facility administrators under §1919(f)(4). [For §1908 as it formerly read, see Vol. III, P.L. 101-508..]

[345] P.L. 100-93, §4(d); 101 Stat. 689.

[346] P.L. 100-203, §4212(e)(3)(A), struck out "SKILLED NURSING FACILITIES AND". For the effective date, see Vol. II, P.L. 100-203, §4214.

As in original. One "OF" should be stricken.

[347] P.L. 101-239, §6901(d)(5)(A), inserted "AND INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED", effective as if included in the enactment of P.L. 100-203.

See Vol. II, P.L. 95-210, §1(e), with respect to rural health clinics.

[348] P.L. 100-203, §4212(e)(3)(B), struck out subsection (a) and §4212(e)(3)(C) redesignated subsection (b) as subsection (a). For the effective date, see Vol. II, P.L. 100-203, §4214.

(b)(1) The Secretary may cancel approval of any intermediate care facility for the mentally retarded[349] at any time if he finds on the basis of a determination made by him as provided in section 1902(a)(33)(B) that a facility fails to meet the requirements contained in section 1902(a)(31) or section 1905(d)[350], or if he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In that event the Secretary shall notify the State agency and the intermediate care facility for the mentally retarded[351] that approval of eligibility of the facility to participate in the programs established by this title and title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

(2) Any intermediate care facility for the mentally retarded[352] which is dissatisfied with a determination by the Secretary that it no longer qualifies as a[353] intermediate care facility for the mentally retarded[354] for purposes of this title, shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.

INDIAN HEALTH SERVICE FACILITIES[355]

SEC. 1911. [42 U.S.C. 1396j] (a) A facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan[356]), whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act[357]), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as it meets all of the conditions and requirements which are applicable generally to such facilities under this title.

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[349] P.L. 101-239, §6901(d)(5)(B), struck out "skilled nursing or intermediate care facility", and substituted "intermediate care facility for the mentally retarded", effective as if included in the enactment of P.L. 100-203.

[350] P.L. 101-239, §6901(d)(5)(C), struck out "1902(a)(28) or section 1919 or section 1905(c)" and substituted "1902(a)(31) or section 1905(d)", effective as if included in the enactment of P.L. 100-203.

[351] P.L. 101-239, §6901(b)(5)(D), struck out "skilled nursing facility or intermediate care facility", and substituted "intermediate care facility for the mentally retarded", effective as if included in the enactment of P.L. 100-203.

[352] P.L. 101-239, §6901(b)(5)(D), struck out "skilled nursing facility or intermediate care facility", and substituted "intermediate care facility for the mentally retarded", effective as if included in the enactment of P.L. 100-203.

[353] As in original; should be "an".

[354] P.L. 101-239, §6901(b)(5)(D), struck out "skilled nursing facility or intermediate care facility" and substituted "intermediate care facility for the mentally retarded", effective as if included in the enactment of P.L. 100-203.

[355] See Vol. II, P.L. 94-437, §402(c) and (d) with respect to services provided to medicaid eligible Indians and §403 with respect to reports.

See Vol. II, P.L. 100-713, §712, with respect to the provision of services in Montana.

[356] P.L. 100-203, §4211(h)(8), struck out ", intermediate care facility, or skilled" and substituted "or". For the effective date, see Vol. II, P.L. 100-203, §4214.

[357] P.L. 94-437.

(b) Notwithstanding subsection (a), a facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan[358]) which does not meet all of the conditions and requirements of this title which are applicable generally to such facility, but which submits to the Secretary within six months after the date of the enactment of this section[359] an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first twelve months after the month in which such plan is submitted.

(c) The Secretary is authorized to enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided in Indian Health Service facilities to Indians who are eligible for medical assistance under the State plan.

ASSIGNMENT OF RIGHTS OF PAYMENT

SEC. 1912. [42 U.S.C. 1396k] (a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this title, a State plan for medical assistance shall—

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this title and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual is described in section 1902(l)(1)(A) or[360] the individual is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

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[358] P.L. 100-203, §4211(h)(8), struck out ", intermediate care facility, or skilled" and substituted "or". For the effective date, see Vol. II, P.L. 100-203, §4214.

[359] September 30, 1976 [P.L. 94-437; 90 Stat. 1400].

[360] P.L. 101-508, §4606(a), inserted "the individual is described in section 1902(l)(1)(A) or", effective November 5, 1990.

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(2) provide for entering into cooperative arrangements (including financial arrangements), with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under section 454(3)) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the State plan with respect to (A) the enforcement and collection of rights to support or payment assigned under this section and (B) any other matters of common concern.

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

HOSPITAL PROVIDERS OF NURSING FACILITY[361] SERVICES

SEC. 1913. [42 U.S.C. 1396l] (a) Notwithstanding any other provision of this title, payment may be made, in accordance with this section, under a State plan approved under this title for nursing facility[362] services furnished by a hospital which has in effect an agreement under section 1883 and which, with respect to the provision of such services, meets the requirements of subsections (b) through (d) of section 1919[363].

(b)(1) Except as provided in paragraph (3), payment to any such hospital, for any nursing[364] facility services furnished pursuant to subsection (a), shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under the State plan to nursing[365] facilities, respectively, located in the State in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

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[361] P.L. 100-203, §4211(h)(9)(A), struck out "SKILLED NURSING AND INTERMEDIATE CARE" and substituted "NURSING FACILITY". For the effective date, see Vol. II, P.L. 100-203, §4214.

[362] P.L. 100-203, §4211(h)(9)(B)(i), struck out "skilled nursing facility services and intermediate care facility" and substituted "nursing facility". For the effective date, see Vol. II, P.L. 100-203, §4214.

[363] P.L. 100-203, §4211(h)(9)(B)(ii), inserted "and which, with respect to the provision of such services, meets the requirements of subsections (b) through (d) of section 1919". For the effective date, see Vol. II, P.L. 100-203, §4214.

[364] P.L. 100-203, §4211(h)(9)(C)(i), struck out "skilled nursing or intermediate care" and substituted "nursing". For the effective date, see Vol. II, P.L. 100-203, §4214.

[365] P.L. 100-203, §4211(h)(9)(C)(ii), struck out "skilled nursing and intermediate care" and substituted "nursing". For the effective date, see Vol. II, P.L. 100-203, §4214.

(2) With respect to any period for which a hospital has an agreement under section 1883, in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services due from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital total routine costs before calculations are made to determine reimbursement for routine hospital services under the State plan.

(3) Payment to all such hospitals, for any nursing[366] facility services furnished pursuant to subsection (a), may be made at a payment rate established by the State in accordance with the requirements of section 1902(a)(13)(A).

WITHHOLDING OF FEDERAL SHARE OF PAYMENTS FOR CERTAIN MEDICARE PROVIDERS

SEC. 1914. [42 U.S.C. 1396m] (a) The Secretary may adjust, in accordance with this section, the Federal matching payment to a State with respect to expenditures for medical assistance for care or services furnished in any quarter by—

(1) an institution (A) which has or previously had in effect an agreement with the Secretary under section 1866; and (B)(i) from which the Secretary has been unable to recover overpayments made under title XVIII, or (ii) from which the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under title XVIII; and

(2) any person (A) who (i) has previously accepted payment on the basis of an assignment under section 1842(b)(3)(B)(ii), and (ii) during the annual period immediately preceding such quarter submitted no claims for payment under title XVIII, or submitted claims for payment under title XVIII which aggregated less than the amount of overpayments made to him, and (B)(i) from whom the Secretary has been unable to recover overpayments received in violation of the terms of such assignment, or (ii) from whom the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such person under title XVIII.

(b) The Secretary may (subject to the remaining provisions of this section) reduce payment to a State under this title for any quarter by an amount equal to the lesser of the Federal matching share of payments to any institution or person specified in subsection (a), or the total overpayments to such institution or person under title XVIII, and may require the State to reduce its payment to such institution or person by such amount.

(c) The Secretary shall not make any adjustment in the payment to a State, nor require any adjustment in the payment to an institution or person, pursuant to subsection (b) until after he has provided adequate notice (which shall be not less than 60 days) to the State agency and the institution or person.

(d) The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall (1) determine the amount of the Federal payment to which the institution or person would otherwise be entitled under this section which shall be treated as a setoff against overpayments under title XVIII, and (2) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under title XVIII and to which the institution or person would otherwise be entitled under this title.

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[366] P.L. 100-203, §4211(h)(9)(D), struck out "skilled nursing or intermediate care" and substituted "nursing". For the effective date, see Vol. II, P.L. 100-203, §4214.

(e) The Secretary shall restore to the trust funds established under sections 1817 and 1841, as appropriate, amounts recovered under this section as setoffs against overpayments under title XVIII.

(f) Notwithstanding any other provision of this title, an institution or person shall not be entitled to recover from any State any amount in payment for medical care and services under this title which is withheld by the State agency pursuant to an order by the Secretary under subsection (b).

PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN REQUIREMENTS OF THIS TITLE

SEC. 1915. [42 U.S.C. 1396n] (a) A State shall not be deemed to be out of compliance with the requirements of paragraphs (1), (10), or (23) of section 1902(a) solely by reason of the fact that the State (or any political subdivision thereof)—

(1) has entered into—

(A) a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic; or

(B) arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1905(a)(3) or medical devices if the Secretary has found that—

(i) adequate services or devices will be available under such arrangements, and

(ii) any such laboratory services will be provided only through laboratories—

(I) which meet the applicable requirements of section 1861(e)(9) or paragraphs (15) and (16)[367] of section 1861(s), and such additional requirements as the Secretary may require, and

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[367] P.L. 99-509, §9320(h)(3), struck out "(11) and (12)" and substituted "(12) and (13)", applicable to services furnished on or after January 1, 1989. For the applicability of this amendment, see Vol. II, P.L. 99-509, §9320(k), as added by P.L. 100-485 and amended by P.L. 101-239.

P.L. 100-203, §4072(d), struck out "(12) and (13)" and substituted "(13) and (14)". For the effective date, see Vol. II, P.L. 100-203, §4072(e).

P.L. 100-360, §204(d)(3), struck out "(13) and (14)" and substituted "(14) and (15)", applicable to screening mammography performed on or after January 1, 1990.

P.L. 101-234, §201(a)(1), struck out "(14) and (15)" and substituted "(13) and (14)", effective January 1, 1990.

P.L. 101-239, §6115(c), struck out "(14) and (15)" and substituted "(15) and (16)", applicable to screening pap smears performed on or after July 1, 1990. Executed as if §6115(c) reads "by striking 'paragraphs (13) and (14)' . . .".

(II) no more than 75 percent of whose charges for such services are for services provided to individuals who are entitled to benefits under this title or under part A or part B of title XVIII; or

(2) restricts for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if—

(A) the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), and

(B) under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.

(b) The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this title, may waive such requirements of section 1902 (other than subsection (s))[368] (other than sections 1902(a)(13)(E) and 1902(a)(10)(A) insofar as it requires provision of the care and services described in section 1905(a)(2)(C))[369] as may be necessary for a State—

(1) to implement a primary care case-management system or a specialty physician services arrangement which restricts the provider from (or through) whom an individual (eligible for medical assistance under this title) can obtain medical care services (other than in emergency circumstances), if such restriction does not substantially impair access to such services of adequate quality where medically necessary,

(2) to allow a locality to act as a central broker in assisting individuals (eligible for medical assistance under this title) in selecting among competing health care plans, if such restriction does not substantially impair access to services of adequate quality where medically necessary,

(3) to share (through provision of additional services) with recipients of medical assistance under the State plan cost savings resulting from use by the recipient of more cost-effective medical care, and

(4) to restrict the provider from (or through) whom an individual (eligible for medical assistance under this title) can obtain services (other than in emergency circumstances) to providers or practitioners who undertake to provide such services and who meet, accept, and comply with the reimbursement, quality, and utilization standards under the State plan, which standards shall

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[368] P.L. 101-508, §4604(c), inserted "(other than subsection (s))" after "Section 1902", effective for payments under title XIX for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date. Executed as if "Section 1902" read "section 1902".

See Vol. II, P.L. 101-508, §4604(d)(2), in the case of a State plan requiring legislation.

[369] P.L. 101-508, §4704(b)(3) inserted "(other than sections 1902(a)(13)(E) and 1902(a)(10)(A) insofar as it requires provision of the care and services described in section 1905(a)(2)(C))" after "section 1902", effective as if included in the enactment of P.L. 101-239. Executed as if "section 1902" read "subsection (s))".

be consistent with the requirements of section 1923 and[370] are consistent with access, quality, and efficient and economic provision of covered care and services, if such restriction does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services and if providers under such restriction are paid on a timely basis in the same manner as health care practitioners must be paid under section 1902(a)(37)(A)[371].

No waiver under this subsection may restrict the choice of the individual in receiving services under section 1905(a)(4)(C).[372]

(c)(1) The Secretary may by waiver provide that a State plan approved under this title may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded[373] the cost of which could be reimbursed under the State plan[374]. For purposes of this subsection, the term "room and board" shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.[375]

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) the State will provide, with respect to individuals who—

(i) are entitled to medical assistance for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded[376] under the State plan,

(ii) may require such services, and

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[370] P.L. 101-239, §6411(c)(2), inserted "shall be consistent with the requirements of section 1923 and", effective as if included in the enactment of P.L. 100-203.

[371] P.L. 101-508, §4742(a), inserted "and if providers under such restriction are paid on a timely basis in the same manner as health care practitioners must be paid under section 1902(a)(37)(A)", effective as of January 1, 1991.

[372] See Vol. II, P.L. 99-272, §9524, with respect to the Wisconsin health maintenance organization waiver.

[373] P.L. 100-203, §4211(h)(10)(A), struck out "skilled nursing facility or intermediate care facility" and substituted "nursing facility or intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[374] See Vol. II, P.L. 99-272, §9502(f), with respect to waiver extensions.

[375] P.L. 101-508, §4741(a), added this sentence, effective November 5, 1990.

[376] P.L. 100-203, §4211(h)(10)(B), struck out ", skilled nursing facility, or intermediate care facility services" and substituted "services, nursing facility services, or services in an intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

(iii) may be eligible for such home or community-based care under such waiver,

for an evaluation of the need for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded[377];

(C) such individuals who are determined to be likely to require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded[378] are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded[379];

(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(E) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.[380]

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community). A waiver under this subsection shall be for an initial term of three years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.

(4) A waiver granted under this subsection may, consistent with paragraph (2)—

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[377] P.L. 99-509, §9411(a)(2)(B), inserted "inpatient hospital," after "need for", applicable to applications for waivers (or renewals thereof) approved on or after October 21, 1986.

P.L. 100-203, §4118(p)(10), effective as if included in the enactment of P.L. 99-509, amended section 9411(a)(2)(B) of such Act by inserting "such" after "need for".

P.L. 100-203, §4211(h)(10)(C), struck out "need for such inpatient hospital, skilled nursing facility or intermediate care facility services" and substituted "need for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[378] P.L. 100-203, §4211(h)(10)(D), struck out "or skilled nursing facility or intermediate care facility" and substituted ", nursing facility, or intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[379] P.L. 100-203, §4211(h)(10)(E), struck out "or skilled nursing facility or intermediate care facility services" and substituted ", nursing facility services, or services in an intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[380] See Vol. II, P.L. 101-508, §4742(e), with respect to adjustments in estimates to take into account preadmission screening requirement.

(A) limit the individuals provided benefits under such waiver to individuals with respect to whom the State has determined that there is a reasonable expectation that the amount of medical assistance provided with respect to the individual under such waiver will not exceed the amount of such medical assistance provided for such individual if the waiver did not apply, and

(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.

Except as provided under paragraph (2)(D), the Secretary may not restrict the number of hours or days of respite care in any period which a State may provide under a waiver under this subsection.[381]

(5) For purposes of paragraph (4)(B), the term "habilitation services", with respect to individuals who receive such services after discharge from a nursing facility or intermediate care facility for the mentally retarded[382]—

(A) means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings; and

(B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services; but

(C) does not include—

(i) special education and related services (as defined in section 602(16) and (17) of the Education of the Handicapped Act[383] (20 U.S.C. 1401(16), (17)) which otherwise are available to the individual through a local educational agency; and

(ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973[384] (29 U.S.C. 730).

(6) The Secretary may not require, as a condition of approval of a waiver under this section under paragraph (2)(D), that the actual total expenditures for home and community-based services under the waiver (and a claim for Federal financial participation in expenditures for the services) cannot exceed the approved estimates for these services. The Secretary may not deny Federal financial payment with respect to services under such a waiver on the ground that, in

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[381] P.L. 101-508, §4742(d)(1), added this sentence, applicable as if included in the enactment of P.L. 97-35.

[382] P.L. 100-203, §4211(h)(10)(F), struck out "skilled nursing facility or intermediate care facility" and substituted "nursing facility or intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[383] P.L. 91-230; Title VI.

P.L. 101-476, §901(a)(3), provides that any other Act and any regulation which refers to the Education of the Handicapped Act shall be considered to refer to the Individuals with Disabilities Education Act.

[384] P.L. 93-112.

order to comply with paragraph (2)(D), a State has failed to comply with such a requirement.

(7)(A) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with a particular illness or condition who are inpatients in, or who would require the level of care provided in, hospitals, nursing facilities, or intermediate care facilities for the mentally retarded[385], the State may determine the average per capita expenditure that would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients in, or who would require the level of care provided in, those respective facilities.

(B) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with developmental disabilities who are inpatients in a nursing facility[386] and whom the State has determined, on the basis of an evaluation under paragraph (2)(B), to need the level of services provided by an intermediate care facility for the mentally retarded, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals under the State plan on the basis of the average per capita expenditures under the State plan for services to individuals who are inpatients in an intermediate care facility for the mentally retarded, without regard to the availability of beds for such inpatients.

(C) In making estimates under paragraph (2)(D) in the case of a waiver to the extent that it applies to individuals with mental retardation or a related condition who are resident in an intermediate care facility for the mentally retarded the participation of which under the State plan is terminated, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals without regard to any such termination.[387]

(8) The State agency administering the plan under this title may, whenever appropriate, enter into cooperative arrangements with the State agency responsible for administering the program for children with special health care needs under title V in order to assure improved access to coordinated services to meet the needs of such children.

(9) In the case of any waiver under this subsection which contains a limit on the number of individuals who shall receive home or community-based services, the State may substitute additional individuals to receive such services to replace any individuals who die or become ineligible for services under the State plan.

(10) The Secretary shall not limit to fewer than 200 the number of individuals in the State who may receive home and community-based services under a waiver under this subsection.

(d)(1) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this title shall include as

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[385] P.L. 100-203, §4211(h)(10)(G), struck out "or in skilled nursing or intermediate care facilities" and substituted ", nursing facilities, or intermediate care facilities for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

[386] P.L. 100-203, §4211(h)(10)(G) [as amended by P.L. 100-360, §411(l)(3)(G)], struck out "skilled nursing facility or intermediate care facility" and substituted "nursing facility". For the effective date, see Vol. II, P.L. 100-203, §4214.

[387] P.L. 101-508, §4742(c)(1), added subparagraph (C), applicable as if included in the enactment of P.L. 97-35, but shall only apply to facilities the participation of which under a State plan under title XIX is terminated on or after November 5, 1990.

"medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) which are provided pursuant to a written plan of care to individuals 65 years of age or older with respect to whom there has been a determination that but for the provision of such services the individuals would be likely to require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term "room and board" shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.[388]

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) with respect to individuals 65 years of age or older who—

(i) are entitled to medical assistance for skilled nursing or intermediate care facility services under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based services under such waiver,

the State will provide for an evaluation of the need for such skilled nursing facility or intermediate care facility services; and

(C) such individuals who are determined to be likely to require the level of care provided in a skilled nursing facility or intermediate care facility are informed of the feasible alternatives to the provision of skilled nursing facility or intermediate care facility services, which such individuals may choose if available under the waiver.

Each State with a waiver under this subsection shall provide to the Secretary annually, consistent with a reasonable data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community). Subject to a termination by the State (with notice to the Secretary) at any time, a waiver under this subsection shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may

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[388] P.L. 101-508, §4741(a), added this sentence, effective November 5, 1990.

provide, with respect to post-eligibility treatment of income of all individuals receiving services under the waiver, that the maximum amount of the individual's income which may be disregarded for any month is equal to the amount that may be allowed for that purpose under a waiver under subsection (c).

(4) A waiver under this subsection may, consistent with paragraph (2), provide medical assistance to individuals for case management services, homemaker/home health aide services and personal care services, adult day health services, respite care, and other medical and social services that can contribute to the health and well-being of individuals and their ability to reside in a community-based care setting.

(5)(A) In the case of a State having a waiver approved under this subsection, notwithstanding any other provision of section 1903 to the contrary, the total amount expended by the State for medical assistance with respect to skilled nursing facility services, intermediate care facility services, and home and community-based services under the State plan for individuals 65 years of age or older during a waiver year under this subsection may not exceed the projected amount determined under subparagraph (B).

(B) For purposes of subparagraph (A), the projected amount under this subparagraph is the sum of the following:

(i) The aggregate amount of the State's medical assistance under this title for skilled nursing facility services and intermediate care facility services furnished to individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of—

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(ii) The aggregate amount of the State's medical assistance under this title for home and community-based services for individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of—

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(iii) The Secretary shall develop and promulgate by regulation (by not later than October 1, 1989)—

(I) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise both skilled nursing facility services and intermediate care facility services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (i)(I);

(II) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise home and community-based services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (ii)(I); and

(III) a method for projecting, on a State specific basis, the percentage increase in the number of residents in each State who are over 65 years of age for any period.

The Secretary shall develop (by not later than October 1, 1989) a method for projecting, on a State-specific basis, the percentage increase in the number of residents in each State who are over 75[389] years of age for any period. Effective on and after the date the Secretary promulgates the regulation under clause (iii), any reference in this subparagraph to the "lesser of 7 percent" shall be deemed to be a reference to the "greater of 7 percent".[390]

(iv) If there is enacted after December 22, 1987, an Act which amends this title whose provisions become effective on or after such date[391] and which results in an increase in the aggregate amount of medical assistance under this title for nursing facility services and home and community-based services for individuals who have attained the age of 65 years, the Secretary, at the request of a State with a waiver under this subsection for a waiver year or years and in close consultation with the State, shall adjust the projected amount computed under this subparagraph for the waiver year or years to take into account such increase.[392]

(C) In this paragraph:

(i) The term "home and community-based services" includes services described in sections 1905(a)(7) and 1905(a)(8), services described in subsection (c)(4)(B), services described in paragraph (4), and personal care services.

(ii)(I) Subject to subclause (II), the term "base year" means the most recent year (ending before the date of the enactment of this subsection) for which actual final expenditures under this title have been reported to, and accepted by, the Secretary.

(II) For purposes of subparagraph (C), in the case of a State that does not report expenditures on the basis of the age categories described in such subparagraph for a year ending before the date of the enactment of this subsection, the term "base year" means fiscal year 1989.

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[389] As in original. Possibly should be "65".

[390] Alignment as in original.

[391] P.L. 101-508, §4741(b), inserted "whose provisions become effective on or after such date", effective November 5, 1990.

[392] Alignment as in original.

(iii) The term "intermediate care facility services" does not include services furnished in an institution certified in accordance with section 1905(d).

(6)(A) A determination by the Secretary to deny a request for a waiver (or extension of waiver) under this subsection shall be subject to review to the extent provided under section 1116(b).

(B) Notwithstanding any other provision of this Act, if the Secretary denies a request of the State for an extension of a waiver under this subsection, any waiver under this subsection in effect on the date such request is made shall remain in effect for a period of not less than 90 days after the date on which the Secretary denies such request (or, if the State seeks review of such determination in accordance with subparagraph (A), the date on which a final determination is made with respect to such review).

(e)(1)(A) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this title shall include as "medical assistance" under such plan payment for part or all of the cost of nursing care, respite care, physicians' services, prescribed drugs, medical devices and supplies, transportation services, and such other services requested by the State as the Secretary may approve which are provided pursuant to a written plan of care to a child described in subparagraph (B) with respect to whom there has been a determination that but for the provision of such services the infants would be likely to require the level of care provided in a hospital or nursing facility the cost of which could be reimbursed under the State plan.

(B) Children described in this subparagraph are individuals under 5 years of age who—

(i) at the time of birth were infected with (or tested positively for) the etiologic agent for acquired immune deficiency syndrome (AIDS),

(ii) have such syndrome, or

(iii) at the time of birth were dependent on heroin, cocaine, or phencyclidine,

and with respect to whom adoption or foster care assistance is (or will be) made available under part E of title IV.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(C) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(B) (relating to comparability). A waiver under this subsection shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met.

(4) The provisions of paragraph (6) of subsection (d) shall apply to this subsection in the same manner as it applies to subsection (d).

(f)(1) The Secretary shall monitor the implementation of waivers granted under this section to assure that the requirements for such waiver are being met and shall, after notice and opportunity for a hearing, terminate any such waiver where he finds noncompliance has occurred.

(2) A request to the Secretary from a State for approval of a proposed State plan or plan amendment or a waiver of a requirement of this title submitted by the State pursuant to a provision of this title shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

(g)(1) A State may provide, as medical assistance, case management services under the plan without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B). The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1902(a)(23). A State may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS), or with AIDS-related conditions, or with either, and a State may limit the provision of case management services under this subsection to individuals with chronic mental illness. The State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.

(2) For purposes of this subsection, the term "case management services" means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

(h) No waiver under this section (other than a waiver under subsection (c), (d), or (e)) may extend over a period of longer than two years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 day[393] of such date, denies such request.

USE OF ENROLLMENT FEES, PREMIUMS, DEDUCTIONS, COST SHARING, AND SIMILAR CHARGES

SEC. 1916. [42 U.S.C. 1396o] (a) The State plan shall provide that in the case of individuals described in subparagraph (A) or (E)(i)[394] of section 1902(a)(10) who are eligible under the plan—

(1) no enrollment fee, premium, or similar charge will be imposed under the plan (except for a premium imposed under subsection (c));

(2) no deduction, cost sharing or similar charge will be imposed under the plan with respect to—

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy (or, at the option of the State, any services furnished to pregnant women),

(C) services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded[395], or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs,

(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1905(a)(4)(C), or services furnished to such an individual by a health maintenance organization (as defined in section 1903(m)) in which he is enrolled, or

(E) services furnished to an individual who is receiving hospice care (as defined in section 1905(o)); and

(3) any deduction, cost sharing, or similar charge imposed under the plan with respect to other such individuals or other care and services will be nominal in amount (as determined by the Secretary in regulations which shall, if the definition of "nominal" under the regulations in effect on July 1, 1982 is changed, take into account the level of cash assistance provided in such State and such other criteria as the Secretary determines to be appropriate); except that a deduction, cost-sharing, or similar charge of up to twice the nominal amount established for outpatient services may be imposed by a State under a

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[393] As in original. Probably should be "days".

[394] P.L. 101-239, §6408(d)(3)(A), inserted "(i)".

[395] P.L. 100-203, §4211(h)(11), struck out "skilled nursing facility, intermediate care facility" and substituted "nursing facility, intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

waiver granted by the Secretary for services received at a hospital emergency room if the services are not emergency services (referred to in paragraph (2)(D)) and the State has established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services.

(b) The State plan shall provide that in the case of individuals other than those described in subparagraph (A) or (E) of section 1902(a)(10) who are eligible under the plan—

(1) there may be imposed an enrollment fee, premium, or similar charge, which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income,

(2) no deduction, cost sharing, or similar charge will be imposed under the plan with respect to—

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy (or, at the option of the State, any services furnished to pregnant women),

(C) services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded[396], or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs,

(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1905(a)(4)(C), or (at the option of the State) services furnished to such an individual by a health maintenance organization (as defined in section 1903(m)) in which he is enrolled, or

(E) services furnished to an individual who is receiving hospice care (as defined in section 1905(o)); and

(3) any deduction, cost sharing, or similar charge imposed under the plan with respect to other such individuals or other care and services will be nominal in amount (as determined by the Secretary in regulations which shall, if the definition of "nominal" under the regulations in effect on July 1, 1982 is changed, take into account the level of cash assistance provided in such State and such other criteria as the Secretary determines to be appropriate); except that a deduction, cost-sharing, or similar charge of up to twice the nominal amount established for outpatient services may be imposed by a State under a waiver granted by the Secretary for services received at a hospital emergency room if the services are not emergency services (referred to in paragraph (2)(D)) and the State has

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[396] P.L. 100-203, §4211(h)(11), struck out "skilled nursing facility, intermediate care facility" and substituted "nursing facility, intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services.

(c)(1) The State plan of a State may at the option of the State provide for imposing a monthly premium (in an amount that does not exceed the limit established under paragraph (2)) with respect to an individual described in subparagraph (A) or (B) of section 1902(l)(1) who is receiving medical assistance on the basis of section 1902(a)(10)(A)(ii)(IX) and whose family income (as determined in accordance with the methodology specified in section 1902(l)(3)) equals or exceeds 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(2) In no case may the amount of any premium imposed under paragraph (1) exceed 10 percent of the amount by which the family income (less expenses for the care of a dependent child) of an individual exceeds 150 percent of the line described in paragraph (1).

(3) A State shall not require prepayment of a premium imposed pursuant to paragraph (1) and shall not terminate eligibility of an individual for medical assistance under this title on the basis of failure to pay any such premium until such failure continues for a period of not less than 60 days. The State may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

(4) A State may permit State or local funds available under other programs to be used for payment of a premium imposed under paragraph (1). Payment of a premium with such funds shall not be counted as income to the individual with respect to whom such payment is made.

(d) With respect to a qualified disabled and working individual described in section 1905(s) whose income (as determined under paragraph (3) of that section) exceeds 150 percent of the official poverty line referred to in that paragraph, the State plan of a State may provide for the charging of a premium (expressed as a percentage of the medicare cost-sharing described in section 1905(p)(3)(A)(i) provided with respect to the individual) according to a sliding scale under which such percentage increases from 0 percent to 100 percent, in reasonable increments (as determined by the Secretary), as the individual's income increases from 150 percent of such poverty line to 200 percent of such poverty line.[397]

(e)[398]The State plan shall require that no provider participating under the State plan may deny care or services to an individual eligible for such care or services under the plan on account of such individual's inability to pay a deduction, cost sharing, or similar charge. The requirements of this subsection shall not extinguish the liability of the individual to whom the care or services were furnished for payment of the deduction, cost sharing, or similar charge.

(f)[399]No deduction, cost sharing, or similar charge may be imposed under any waiver authority of the Secretary, except as provided in subsections (a)(3) and (b)(3), unless such waiver is for a demonstration project which the Secretary finds after public notice and opportunity for comment—

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[397] P.L. 101-239, §6408(d)(3)(C), added this subsection (d). For the effective date, see Vol. II, P.L. 101-239, §6408(d)(5).

[398] P.L. 101-239, §6408(d)(3)(B), redesignated subsection (d) as subsection (e).

[399] P.L. 101-239, §6408(d)(3)(B), redesignated subsection (e) as subsection (f).

(1) will test a unique and previously untested use of copayments,

(2) is limited to a period of not more than two years,

(3) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients,

(4) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and

(5) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

LIENS, ADJUSTMENTS AND RECOVERIES, AND TRANSFERS OF ASSETS

SEC. 1917. [42 U.S.C. 1396p] (a)(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual—

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded[400], or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if—

(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution),

is lawfully residing in such home.

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[400] P.L. 100-203, §4211(h)(12)(A), struck out "skilled nursing facility, intermediate care facility" and substituted "nursing facility, intermediate care facility for the mentally retarded". For the effective date, see Vol. II, P.L. 100-203, §4214.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

(b)(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except—

(A) in the case of an individual described in subsection (a)(1)(B), from his estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of such individual, and

(B) in the case of any other individual who was 65 years of age or older when he received such assistance, from his estate.

(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual's surviving spouse, if any, and only at a time—

(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614; and

(B) in the case of a lien on an individual's home under subsection (a)(1)(B), when—

(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), and

(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution),

is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

(c)(1) In order to meet the requirements of this subsection (for purposes of section 1902(a)(51)(B)), the State plan must provide for a period of ineligibility for nursing facility services and for a level of care in a medical institution equivalent to that of nursing facility services and for services under section 1915(c) in the case of an institutionalized individual (as defined in paragraph (3)) who, or whose spouse,[401] at any time during or after the 30-month period immediately before the date the individual becomes an institutionalized individual (if the individual is entitled to medical assistance under the State plan on such date) or, if the individual is not so entitled, the date the individual applies for such assistance while an institutionalized individual, disposed of resources for less than fair market value. The period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to the lesser of—

(A) 30 months, or

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[401] P.L. 101-239, §6411(e)(1)(A), inserted "or whose spouse,", applicable to transfers occurring after December 19, 1989.

(B)(i) the total uncompensated value of the resources so transferred, divided by (ii) the average cost, to a private patient at the time of the application, of nursing facility services in the State or, at State option, in the community in which the individual is institutionalized.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A) the resources transferred were a home and title to the home was transferred to—

(i) the spouse of such individual;

(ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614;

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the resources were transferred (i) to or from (or to another for the sole benefit of) the individual's spouse, or[402] (ii) to the individual's child described in subparagraph (A)(ii)(II)[403];

(C) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that (i) the individual intended to dispose of the resources either at fair market value, or for other valuable consideration, or (ii) the resources were transferred exclusively for a purpose other than to qualify for medical assistance; or

(D) the State determines that denial of eligibility would work an undue hardship.

(3) In this subsection, the term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1902(a)(10)(A)(ii)(VI).

(4) A State (including a State which has elected treatment under section 1902(f)) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection.[404]

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[402] P.L. 101-239, §6411(e)(1)(B)(i), amended clause (i) in its entirety, applicable to transfers occurring after December 19, 1989. [For clause (i) as it formerly read, see Vol. III, P.L. 101-239.]

[403] P.L. 101-239, §6411(e)(1)(B)(ii), struck out ", or" and clause (iii), applicable to transfers occurring after December 19, 1989. [For clause (iii) as it formerly read, see Vol. III, P.L. 101-239.]

[404] P.L. 100-360, §303(b), amended subsection (c) in its entirety. For the effective date, see Vol. II, P.L. 100-360, §303(g). [For subsection (c) as it formerly read, see Vol. III, P.L. 100-360.]

(5) In this subsection, the term "resources" has the meaning given such term in section 1613, without regard to the exclusion described in subsection (a)(1) thereof.

APPLICATION OF PROVISIONS OF TITLE II RELATING TO SUBPOENAS

SEC. 1918. [42 U.S.C. 1396q] The provisions of subsections (d) and (e) of section 205 of this Act shall apply with respect to this title to the same extent as they are applicable with respect to title II.

REQUIREMENTS FOR NURSING FACILITIES[405]

SEC. 1919. [42 U.S.C. 1396r] (a) NURSING FACILITY DEFINED.—In this title, the term "nursing facility" means an institution (or a distinct part of an institution) which—

(1) is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care,

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

(C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities,

and is not primarily for the care and treatment of mental diseases;

(2) has in effect a transfer agreement (meeting the requirements of section 1861(l)) with one or more hospitals having agreements in effect under section 1866; and

(3) meets the requirements for a nursing facility described in subsections (b), (c), and (d) of this section.

Such term also includes any facility which is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of paragraph (1) and subsections (b), (c), and (d).

(b) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—

(1) QUALITY OF LIFE.—

(A) IN GENERAL.—A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(B) QUALITY ASSESSMENT AND ASSURANCE.—A nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.[406]

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[405] P.L. 100-203, §4211(a)(3), added this §1919. For the effective date, see Vol. II, P.L. 100-203, §4214.
See Vol. II, P.L. 100-203, §4215, with respect to a report to Congress.

(2) Scope of services and activities under plan of care.—A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which—

(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

(3) Residents' assessment.—

(A) Requirement.—A nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);

(iii) uses an instrument which is specified by the State under subsection (e)(5); and

(iv) includes the identification of medical problems.

(B) Certification.—

(i) In general.—Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

(ii) Penalty for falsification.—

(I) An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 with respect to each assessment.

(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 with respect to each assessment.

(III) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

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[406] P.L. 101-508, §4801(e)(2), added this sentence, effective as if included in the enactment of P.L. 100-203.

(iii) Use of independent assessors.—If a State determines, under a survey under subsection (g) or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(C) Frequency.—

(i) In general.—Such an assessment must be conducted—

(I) promptly upon (but no later than not to exceed 14[407] days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than October 1, 1991, for each resident of the facility on that date;

(II) promptly after a significant change in the resident's physical or mental condition; and

(III) in no case less often than once every 12 months.

(ii) Resident review.—The nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

(D) Use.—The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

(E) Coordination.—Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort.

(F) Requirements relating to preadmission screening for mentally ill and mentally retarded individuals.—Except as provided in clauses (ii) and (iii) of subsection (e)(7)(A), a[408] nursing facility must not admit, on or after January 1, 1989, any new resident who—

(i) is mentally ill (as defined in subsection (e)(7)(G)(i)) unless the State mental health authority has determined (based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority) prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires specialized services[409] for mental illness, or

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[407] P.L. 101-508, §4801(e)(3), struck out "4" and substituted "not to exceed 14", effective as if included in the enactment of P.L. 100-203.

[408] P.L. 101-508, §4801(b)(2)(A), struck out "A" and substituted "Except as provided in clauses (ii) and (iii) of subsection (e)(7)(A), a", effective as if included in the enactment of P.L. 100-203.

[409] P.L. 101-508, §4801(b)(8), struck out "active treatment" and substituted "specialized services", effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

(ii) is mentally retarded (as defined in subsection (e)(7)(G)(ii)) unless the State mental retardation or developmental disability authority has determined prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires specialized services[410] for mental retardation.

A State mental health authority and a State mental retardation or developmental disability authority may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).[411]

(4) PROVISION OF SERVICES AND ACTIVITIES.—

(A) IN GENERAL.—To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of)—

(i) nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident;[412]

(vi) routine dental services (to the extent covered under the State plan) and emergency dental services to meet the needs of each resident; and[413]

(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.[414]

The services provided or arranged by the facility must meet professional standards of quality.

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[410] P.L. 101-508, §4801(b)(8), struck out "active treatment" and substituted "specialized services", effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

[411] P.L. 101-508, §4801(b)(4)(A), added this sentence, effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

[412] P.L. 101-508, §4801(e)(4)(A), struck out "and".

[413] P.L. 101-508, §4801(e)(4)(B), struck out a period and substituted "; and".

[414] P.L. 101-508, §4801(e)(4)(C), added clause (vii), effective as if included in the enactment of P.L. 100-203.

See Vol. II, P.L. 101-508, §4801(e)(17)(A), with respect to maintaining regulatory standards for certain services.

(B) Qualified persons providing services.—Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

(C) Required nursing care; facility waivers.—

(i) General requirements.—With respect to nursing facility services provided on or after October 1, 1990, a nursing facility—

(I) except as provided in clause (ii), must provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents, and

(II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week.

(ii) Waiver by state.—To the extent that a facility is unable to meet the requirements of clause (i), a State may waive such requirements with respect to the facility if[415]—

(I) the facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel,

(II) the State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility,[416]

(III) the State finds that, for any such periods in which licensed nursing services are not available, a registered professional nurse or a physician is obligated to respond immediately to telephone calls from the facility,[417]

(IV) the State agency granting a waiver of such requirements provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and[418]

(V) the nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.[419]

A waiver under this clause shall be subject to annual review and to the review of the Secretary and subject to clause (iii) shall be accepted by the Secretary for purposes of this title to the same extent as is the State's certification of the facility. In granting or renewing a waiver, a State may require the facility to use other qualified, licensed personnel.

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[415] P.L. 101-508, §4801(e)(5)(A), struck out "A State may waive the requirement of subclause (I) or (II) of clause (i) with respect to a facility if" and substituted "To the extent that a facility is unable to meet the requirements of clause (i), a State may waive such requirements with respect to the facility if", effective as if included in the enactment of P.L. 100-203.

[416] P.L. 101-508, §4801(e)(5)(B), struck out "and".

[417] P.L. 101-508, §4801(e)(5)(C), struck out a period and substituted a comma.

[418] P.L. 101-508, §4801(e)(5)(D), added subclause (IV), effective as if included in the enactment of P.L. 100-203.

[419] P.L. 101-508, §4801(e)(5)(D), added subclause (V), effective as if included in the enactment of P.L. 100-203.

(iii) ASSUMPTION OF WAIVER AUTHORITY BY SECRETARY.—If the Secretary determines that a State has shown a clear pattern and practice of allowing waivers in the absence of diligent efforts by facilities to meet the staffing requirements, the Secretary shall assume and exercise the authority of the State to grant waivers.

(5) REQUIRED TRAINING OF NURSE AIDES.—

(A) IN GENERAL.—(i) Except as provided in clause (ii), a[420] nursing facility must not use on a full-time basis[421] any individual as a nurse aide in the facility on or after October[422] 1, 1990, for more than 4 months unless the individual—

(I)[423] has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A), and

(II)[424] is competent to provide nursing or nursing-related services.[425]

(ii) A nursing facility must not use on a temporary, per diem, leased, or on any other basis other than as a permanent employee any individual as a nurse aide in the facility on or after January 1, 1991, unless the individual meets the requirements described in clause (i).[426]

(B) OFFERING COMPETENCY EVALUATION PROGRAMS FOR CURRENT EMPLOYEES.—A nursing facility must provide, for individuals used as a nurse aide by the facility as of January 1, 1990[427], for a competency evaluation program approved by the State under subsection (e)(1) and such preparation as may be necessary for the individual to complete such a program by October[428] 1, 1990.

(C) COMPETENCY.—The nursing facility must not permit an individual, other than in a training and competency evaluation program approved by the State, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use such an individual as a nurse aide unless the facility has inquired of any State registry established under subsection (e)(2)(A) that the facility believes will include information[429] concerning the individual.

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[420] P.L. 101-508, §4801(a)(2)(i), struck out "A" and substituted "(i) Except as provided in clause (ii), a", effective as if included in the enactment of P.L. 100-203.

[421] P.L. 101-508, §4801(a)(2)(ii), struck out "(on a full-time, temporary, per diem, or other basis)" and substituted "on a full-time basis", effective as if included in the enactment of P.L. 100-203.

[422] P.L. 101-239, §6901(b)(1)(A), struck out "January" and substituted "October", effective as if included in the enactment of P.L. 100-203.

[423] P.L. 101-508, §4801(a)(2)(iii), struck out "(i)" and substituted "(I)".

[424] P.L. 101-508, §4801(a)(2)(iii), struck out "(ii)" and substituted "(II)".

[425] See Vol. II, P.L. 101-239, §6901(b)(4)(B)-(D), with respect to a delay and transition in 75-hour training program requirement.

[426] P.L. 101-508, §4801(a)(2)(iv), added clause (ii), effective as if included in the enactment of P.L. 100-203.

[427] P.L. 101-239, §6901(b)(1)(B), struck out "July 1, 1989" and substituted "January 1, 1990", effective as if included in the enactment of P.L. 100-203.

[428] P.L. 101-239, §6901(b)(1)(B), struck out "January " and substituted "October", effective as if included in the enactment of P.L. 100-203.

(D) RE-TRAINING REQUIRED.—For purposes of subparagraph (A), if, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual shall complete a new training and competency evaluation program, or a new competency evaluation program.[430]

(E) REGULAR IN-SERVICE EDUCATION.—The nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments.

(F) NURSE AIDE DEFINED.—In this paragraph, the term "nurse aide" means any individual providing nursing or nursing-related services to residents in a nursing facility, but does not include an individual—

(i) who is a licensed health professional (as defined in subparagraph (G)) or a registered dietician[431], or

(ii) who volunteers to provide such services without monetary compensation.

(G) LICENSED HEALTH PROFESSIONAL DEFINED.—In this paragraph, the term "licensed health professional" means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

(6) PHYSICIAN SUPERVISION AND CLINICAL RECORDS.—A nursing facility must—

(A) require that the health care of every resident be provided under the supervision of a physician (or, at the option of a State, under the supervision of a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician)[432];

(B) provide for having a physician available to furnish necessary medical care in case of emergency; and

(C) maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)), as well as the results of any pre-admission screening conducted under subsection (e)(7).

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[429] P.L. 101-508, §4801(a)(3), struck out "the State registry established under subsection (e)(2)(A) as to information in the registry" and substituted "any State registry established under subsection (e)(2)(A) that the facility believes will include information", effective as if included in the enactment of P.L. 100-203.

[430] P.L. 101-508, §4801(a)(4), struck out a period and substituted ", or a new competency evaluation program.", effective as if included in the enactment of P.L. 100-203.

[431] P.L. 101-508, §4801(e)(6), inserted "or a registered dietician", effective as if included in the enactment of P.L. 100-203.

[432] P.L. 101-508, §4801(d)(1), inserted "(or, at the option of a State, under the supervision of a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician)", applicable to nursing facility services furnished on or after October 1, 1990, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

(7) Required social services.—In the case of a nursing facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

(c) Requirements Relating to Residents' Rights.—

(1) General rights.—

(A) Specified rights.—A nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) Free choice.—The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(ii) Free from restraints.—The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained)[433].

(iii) Privacy.—The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

(iv) Confidentiality.—The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request[434].

(v) Accommodation of needs.—The right—

(I) to reside and receive services with reasonable accommodation[435] of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

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[433] P.L. 101-239, §6901(d)(4)(A), struck out "Secretary) until such an order could reasonably be obtained " and substituted "Secretary until such an order could reasonably be obtained)", effective as if included in the enactment of P.L. 100-203.

[434] P.L. 101-508, §4801(e)(9), inserted "and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request", effective as if included in the enactment of P.L. 100-203.

[435] P.L. 101-239, §6901(d)(4)(B), struck out "accommodations" and substituted "accommodation", effective as if included in the enactment of P.L. 100-203.

(II) to receive notice before the room or roommate of the resident in the facility is changed.

(vi) GRIEVANCES.—The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(vii) PARTICIPATION IN RESIDENT AND FAMILY GROUPS.—The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

(viii) PARTICIPATION IN OTHER ACTIVITIES.—The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(ix) EXAMINATION OF SURVEY RESULTS.—The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

(x) REFUSAL OF CERTAIN TRANSFERS.—The right to refuse a transfer to another room within the facility, if a purposes of the transfer is to relocate the resident from a portion of the facility that is not a skilled nursing facility (for purposes of title XVIII) to a portion of the facility that is such a skilled nursing facility.[436]

(xi)[437] OTHER RIGHTS.—Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room. A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to medical assistance under this title or a State's entitlement to Federal medical assistance under this title with respect to services furnished to such a resident.[438]

(B) NOTICE OF RIGHTS.—A nursing facility must—

(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility and of the requirements and procedures for establishing eligibility for medical assistance under this title, including the right to request an assessment under section 1924(c)(1)(B);

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[436] P.L. 101-508, §4801(e)(8)(A), added a new clause (x), effective as if included in the enactment of P.L. 100-203.

[437] P.L. 101-508, §4801(e)(8)(A), redesignated clause (x) as clause (xi), effective as if included in the enactment of P.L. 100-203.

[438] P.L. 101-508, §4801(e)(8)(B), added this sentence, effective as if included in the enactment of P.L. 100-203.

(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights) including the notice (if any) of the State developed under subsection (e)(6)[439];

(iii) inform each resident who is entitled to medical assistance under this title—

(I) at the time of admission to the facility or, if later, at the time the resident becomes eligible for such assistance, of the items and services (including those specified under section 1902(a)(28)(B)) that are included in nursing facility services under the State plan and for which the resident may not be charged (except as permitted in section 1916), and of those other items and services that the facility offers and for which the resident may be charged and the amount of the charges for such items and services, and

(II) of changes in the items and services described in subclause (I) and of changes in the charges imposed for items and services described in that subclause; and

(iv) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under title XVIII or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and a statement that a resident may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

(C) RIGHTS OF INCOMPETENT RESIDENTS.—In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this title shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

(D) USE OF PSYCHOPHARMACOLOGIC DRUGS.—Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs.

(2) TRANSFER AND DISCHARGE RIGHTS.—

(A) IN GENERAL.—A nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless—

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[439] P.L. 101-508, §4801(e)(10), inserted "including the notice (if any) of the State developed under subsection (e)(6)", effective as if included in the enactment of P.L. 100-203.

(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) the safety of individuals in the facility is endangered;

(iv) the health of individuals in the facility would otherwise be endangered;

(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this title or title XVIII on the resident's behalf) for a stay at the facility; or

(vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (iv), the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the case described in clause (iv) the documentation must be made by a physician. For purposes of clause (v), in the case of a resident who becomes eligible for assistance under this title after admission to the facility, only charges which may be imposed under this title shall be considered to be allowable.

(B) PRE-TRANSFER AND PRE-DISCHARGE NOTICE.—

(i) IN GENERAL.—Before effecting a transfer or discharge of a resident, a nursing facility must—

(I) notify the resident (and, if known, an immediate family member of the resident or legal representative) of the transfer or discharge and the reasons therefor,

(II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

(III) include in the notice the items described in clause (iii).

(ii) TIMING OF NOTICE.—The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except—

(I) in a case described in clause (iii) or (iv) of subparagraph (A);

(II) in a case described in clause (ii) of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge;

(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

(IV) in a case where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

(iii) ITEMS INCLUDED IN NOTICE.—Each notice under clause (i) must include—

(I) for transfers or discharges effected on or after October 1, 1989, notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (e)(3);

(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965[440]);

(III) in the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals established under part C of the Developmental Disabilities Assistance and Bill of Rights Act[441]; and

(IV) in the case of mentally ill residents (as defined in subsection (e)(7)(G)(i)), the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act[442].

(C) ORIENTATION.—A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(D) NOTICE ON BED-HOLD POLICY AND READMISSION.—

(i) NOTICE BEFORE TRANSFER.—Before a resident of a nursing facility is transferred for hospitalization or therapeutic leave, a nursing facility must provide written information to the resident and an immediate family member or legal representative concerning—

(I) the provisions of the State plan under this title regarding the period (if any) during which the resident will be permitted under the State plan to return and resume residence in the facility, and

(II) the policies of the facility regarding such a period, which policies must be consistent with clause (iii).

(ii) NOTICE UPON TRANSFER.—At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility must provide written notice to the resident and an immediate family member or legal representative of the duration of any period described in clause (i).

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[440] P.L. 89-73.

[441] P.L. 88-164; Title I.

[442] P.L. 99-319.

(iii) PERMITTING RESIDENT TO RETURN.—A nursing facility must establish and follow a written policy under which a resident—

(I) who is eligible for medical assistance for nursing facility services under a State plan,

(II) who is transferred from the facility for hospitalization or therapeutic leave, and

(III) whose hospitalization or therapeutic leave exceeds a period paid for under the State plan for the holding of a bed in the facility for the resident,

will be permitted to be readmitted to the facility immediately upon the first availability of a bed in a semiprivate room in the facility if, at the time of readmission, the resident requires the services provided by the facility.

(E) INFORMATION RESPECTING ADVANCE DIRECTIVES.—A nursing facility must comply with the requirement of section 1902(w) (relating to maintaining written policies and procedures respecting advance directives).[443]

(3) ACCESS AND VISITATION RIGHTS.—A nursing facility must—

(A) permit immediate access to any resident by any representative of the Secretary, by any representative of the State, by an ombudsman or agency described in subclause (II), (III), or (IV) of paragraph (2)(B)(iii), or by the resident's individual physician;

(B) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives of the resident;

(C) permit immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident;

(D) permit reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

(E) permit representatives of the State ombudsman (described in paragraph (2)(B)(iii)(II)), with the permission of the resident (or the resident's legal representative) and consistent with State law, to examine a resident's clinical records.

(4) EQUAL ACCESS TO QUALITY CARE.—

(A) IN GENERAL.—A nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services required under the State plan for all individuals regardless of source of payment.

(B) CONSTRUCTION.—

(i) NOTHING PROHIBITING ANY CHARGES FOR NON-MEDICAID PATIENTS.—Subparagraph (A) shall not be construed as prohibiting a nursing facility from charging any amount for services furnished, consistent with the notice in paragraph (1)(B) describing such charges.

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[443] P.L. 101-508, §4751(b)(2), added subparagraph (E), applicable to services furnished on or after December 1, 1990.

(ii) NO ADDITIONAL SERVICES REQUIRED.—Subparagraph (A) shall not be construed as requiring a State to offer additional services on behalf of a resident than are otherwise provided under the State plan.

(5) ADMISSIONS POLICY.—

(A) ADMISSIONS.—With respect to admissions practices, a nursing facility must—

(i)(I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this title or title XVIII, (II) not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under this title or title XVIII, and (III) prominently display in the facility written information, and provide to such individuals oral and written information, about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits;

(ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility; and

(iii) in the case of an individual who is entitled to medical assistance for nursing facility services, not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan under this title, any gift, money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the individual to the facility or as a requirement for the individual's continued stay in the facility.

(B) CONSTRUCTION.—

(i) NO PREEMPTION OF STRICTER STANDARDS.—Subparagraph (A) shall not be construed as preventing States or political subdivisions therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under the State plan with respect to admissions practices of nursing facilities.

(ii) CONTRACTS WITH LEGAL REPRESENTATIVES.—Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

(iii) CHARGES FOR ADDITIONAL SERVICES REQUESTED.—Subparagraph (A)(iii) shall not be construed as preventing a facility from charging a resident, eligible for medical assistance under the State plan, for items or services the resident has requested and received and that are not specified in the State plan as included in the term "nursing facility services".

(iv) BONA FIDE CONTRIBUTIONS.—Subparagraph (A)(iii) shall not be construed as prohibiting a nursing facility from soliciting, accepting, or receiving a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the resident (or potential resident), but only to the extent that such contribution is not a condition of admission, expediting admission, or continued stay in the facility.

(6) PROTECTION OF RESIDENT FUNDS.—

(A) IN GENERAL.—The nursing facility—

(i) may not require residents to deposit their personal funds with the facility, and

(ii) upon the written authorization of the resident, must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph.

(B) MANAGEMENT OF PERSONAL FUNDS.—Upon written authorization of a resident under subparagraph (A)(ii), the facility must manage and account for the personal funds of the resident deposited with the facility as follows:

(i) DEPOSIT.—The facility must deposit any amount of personal funds in excess of $50 with respect to a resident in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the facility must maintain such funds in a non-interest bearing account or petty cash fund.

(ii) ACCOUNTING AND RECORDS.—The facility must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record.

(iii) NOTICE OF CERTAIN BALANCES.—The facility must notify each resident receiving medical assistance under the State plan under title XIX when the amount in the resident's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the resident's other nonexempt resources) reaches the amount determined under such section the resident may lose eligibility for such medical assistance or for benefits under title XVI.

(iv) CONVEYANCE UPON DEATH.—Upon the death of a resident with such an account, the facility must convey promptly the resident's personal funds (and a final accounting of such funds) to the individual administering the resident's estate.

(C) ASSURANCE OF FINANCIAL SECURITY.—The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(D) LIMITATION ON CHARGES TO PERSONAL FUNDS.—The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under this title or title XVIII.

(7) Limitation on charges in case of medicaid-eligible individuals.—

(A) In general.—A nursing facility may not impose charges, for certain medicaid-eligible individuals for nursing facility services covered by the State under its plan under this title, that exceed the payment amounts established by the State for such services under this title.

(B) Certain medicaid individuals defined.—In subparagraph (A), the term "certain medicaid-eligible individual" means an individual who is entitled to medical assistance for nursing facility services in the facility under this title but with respect to whom such benefits are not being paid because, in determining the amount of the individual's income to be applied monthly to payment for the costs of such services, the amount of such income exceeds the payment amounts established by the State for such services under this title.[444]

(8)[445] Posting of survey results.—A nursing facility must post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility conducted under subsection (g).[446]

(d) Requirements Relating to Administration and Other Matters.—

(1) Administration.—

(A) In general.—A nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5)).

(B) Required notices.—If a change occurs in—

(i) the persons with an ownership or control interest (as defined in section 1124(a)(3)) in the facility,

(ii) the persons who are officers, directors, agents, or managing employees (as defined in section 1126(b)) of the facility,

(iii) the corporation, association, or other company responsible for the management of the facility, or

(iv) the individual who is the administrator or director of nursing of the facility,

the nursing facility must provide notice to the State agency responsible for the licensing of the facility, at the time of the change, of the change and of the identity of each new person, company, or individual described in the respective clause.

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[444] P.L. 101-508, §4801(e)(7)(A)(ii), added a new paragraph (7), effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

[445] P.L. 101-508, §4801(e)(7)(A)(i), redesignated paragraph (7) as paragraph (8), effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

[446] P.L. 100-203, §4212(b) [as amended by P.L. 100-360, §411(l)(6)(B)], added this paragraph. For the effective date, see Vol. II, P.L. 100-203, §4214.

(C) NURSING FACILITY ADMINISTRATOR.—The administrator of a nursing facility must meet standards established by the Secretary under subsection (f)(4).

(2) LICENSING AND LIFE SAFETY CODE.—

(A) LICENSING.—A nursing facility must be licensed under applicable State and local law.

(B) LIFE SAFETY CODE.—A nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel, and

(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in nursing facilities.

(3) SANITARY AND INFECTION CONTROL AND PHYSICAL ENVIRONMENT.—A nursing facility must—

(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

(4) MISCELLANEOUS.—

(A) COMPLIANCE WITH FEDERAL, STATE, AND LOCAL LAWS AND PROFESSIONAL STANDARDS.—A nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1124 and with accepted professional standards and principles which apply to professionals providing services in such a facility.

(B) OTHER.—A nursing facility must meet such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary.

(e) STATE REQUIREMENTS RELATING TO NURSING FACILITY REQUIREMENTS.—As a condition of approval of its plan under this title, a State must provide for the following:

(1) SPECIFICATION AND REVIEW OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND OF NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—The State must—

(A) by not later than January 1, 1989, specify those training and competency evaluation programs, and those competency evaluation programs, that the State approves for purposes of subsection (b)(5) and that meet the requirements established under subsection (f)(2)[447], and

(B) by not later than January 1, 1990, provide for the review and reapproval of such programs, at a frequency and using a methodology consistent with the requirements established under subsection (f)(2)(A)(iii).

The failure of the Secretary to establish requirements under subsection (f)(2) shall not relieve any State of its responsibility under this paragraph.

(2) Nurse aide registry.—

(A) In general.—By not later than January 1, 1989, the State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program, approved under paragraph (1) in the State, or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.[448]

(B) Information in registry.—The registry under subparagraph (A) shall provide (in accordance with regulations of the Secretary) for the inclusion of specific documented findings by a State under subsection (g)(1)(C) of resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings. The State shall make available to the public information in the registry. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement.

(C) Prohibition against charges.—A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).[449]

(3) State appeals process for transfers and discharges.—The State, for transfers and discharges from nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism, meeting the guidelines established under subsection (f)(3), for hearing appeals on transfers and discharges[450] of residents of such facilities; but the failure of the Secretary to establish such guidelines under such subsection shall not relieve any State of its responsibility under this paragraph.

(4) Nursing facility administrator standards.—By not later than July 1, 1989, the State must have implemented and enforced the nursing facility administrator standards developed under subsection (f)(4) respecting the qualification of administrators of nursing facilities.

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[447] P.L. 101-508, §4801(e)(18), struck out "clause (i) or (ii) of subsection (f)(2)(A)", and substituted "subsection (f)(2)", effective as if included in the enactment of P.L. 100-203.

[448] P.L. 101-508, §4801(e)(12)(A), struck out a period and substituted ", or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.", effective as if included in the enactment of P.L. 100-203.

[449] P.L. 101-508, §4801(e)(12)(B), added subparagraph (C), effective as if included in the enactment of P.L. 100-203.

[450] P.L. 100-360, §411(l)(2)(I)(ii), inserted "and discharges", effective as if included in the enactment of P.L. 100-203.

(5) SPECIFICATION OF RESIDENT ASSESSMENT INSTRUMENT.—Effective July 1, 1990, the State shall specify the instrument to be used by nursing facilities in the State in complying with the requirement of subsection (b)(3)(A)(iii). Such instrument shall be—

(A) one of the instruments designated under subsection (f)(6)(B), or

(B) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary under subsection (f)(6)(A).

(6) NOTICE OF MEDICAID RIGHTS.—Each State, as a condition of approval of its plan under this title, effective April 1, 1988, must develop (and periodically update) a written notice of the rights and obligations of residents of nursing facilities (and spouses of such residents) under this title.

(7) STATE REQUIREMENTS FOR PREADMISSION SCREENING AND RESIDENT REVIEW.—

(A) PREADMISSION SCREENING.—

(i) IN GENERAL.—[451]Effective January 1, 1989, the State must have in effect a preadmission screening program, for making determinations (using any criteria developed under subsection (f)(8)) described in subsection (b)(3)(F) for mentally ill and mentally retarded individuals (as defined in subparagraph (G)) who are admitted to nursing facilities on or after January 1, 1989.[452] The failure of the Secretary to develop minimum criteria under subsection (f)(8) shall not relieve any State of its responsibility to have a preadmission screening program under this subparagraph or to perform resident reviews under subparagraph (B).[453]

(ii) CLARIFICATION WITH RESPECT TO CERTAIN READMISSIONS.—The preadmission screening program under clause (i) need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.[454]

(iii) EXCEPTION FOR CERTAIN HOSPITAL DISCHARGES.—The preadmission screening program under clause (i) shall not apply to the admission to a nursing facility of an individual—

(I) who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(II) who requires nursing facility services for the condition for which the individual received care in the hospital, and

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[451] P.L. 101-508, §4801(b)(2)(B)(i), inserted "(i) IN GENERAL.—", effective as if included in the enactment of P.L. 100-203.

[452] P.L. 101-508, §4801(b)(2)(B)(i), redesignated this sentence as part of clause (i), effective as if included in the enactment of P.L. 100-203.

[453] P.L. 101-508, §4801(b)(2)(B)(i), redesignated this sentence as part of clause (i), effective as if included in the enactment of P.L. 100-203.

[454] P.L. 101-508, §4801(b)(2)(B)(ii), added clause (ii), effective as if included in the enactment of P.L. 100-203.

(III) whose attending physician has certified, before admission to the facility, that the individual is likely to require less than 30 days of nursing facility services.[455]

(B) STATE REQUIREMENT FOR ANNUAL RESIDENT REVIEW.—

(i) FOR MENTALLY ILL RESIDENTS.—As of April 1, 1990, in the case of each resident of a nursing facility who is mentally ill, the State mental health authority must review and determine (using any criteria developed under subsection (f)(8) and based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority)—

(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an inpatient psychiatric hospital for individuals under age 21 (as described in section 1905(h)) or of an institution for mental diseases providing medical assistance to individuals 65 years of age or older; and

(II) whether or not the resident requires specialized services[456] for mental illness.

(ii) FOR MENTALLY RETARDED RESIDENTS.—As of April 1, 1990, in the case of each resident of a nursing facility who is mentally retarded, the State mental retardation or developmental disability authority must review and determine (using any criteria developed under subsection (f)(8))—

(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an intermediate care facility described under section 1905(d); and

(II) whether or not the resident requires specialized services[457] for mental retardation.

(iii) FREQUENCY OF REVIEWS.—

(I) ANNUAL.—Except as provided in subclauses (II) and (III), the reviews and determinations under clauses (i) and (ii) must be conducted with respect to each mentally ill or mentally retarded resident not less often than annually.

(II) PREADMISSION REVIEW CASES.—In the case of a resident subject to a preadmission review under subsection (b)(3)(F), the review and determination under clause (i) or (ii) need not be done until the resident has resided in the nursing facility for 1 year.

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[455] P.L. 101-508, §4801(b)(2)(B)(ii), added clause (iii), effective as if included in the enactment of P.L. 100-203.

[456] P.L. 101-508, §4801(b)(8), struck out "active treatment" and substituted "specialized services", effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

[457] P.L. 101-508, §4801(b)(8), struck out "active treatment" and substituted "specialized services", effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

(III) INITIAL REVIEW.—The reviews and determinations under clauses (i) and (ii) must first be conducted (for each resident not subject to preadmission review under subsection (b)(3)(F)) by not later than April 1, 1990.

(iv) PROHIBITION OF DELEGATION.—A State mental health authority, a State mental retardation or developmental disability authority, and a State may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).[458]

(C) RESPONSE TO PREADMISSION SCREENING AND RESIDENT REVIEW.—As of April 1, 1990, the State must meet the following requirements:

(i) LONG-TERM RESIDENTS NOT REQUIRING NURSING FACILITY SERVICES, BUT REQUIRING SPECIALIZED SERVICES[459].—In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require specialized services[460] for mental illness or mental retardation, and who has continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and caregivers—

(I) inform the resident of the institutional and noninstitutional alternatives covered under the State plan for the resident,

(II) offer the resident the choice of remaining in the facility or of receiving covered services in an alternative appropriate institutional or noninstitutional setting,

(III) clarify the effect on eligibility for services under the State plan if the resident chooses to leave the facility (including its effect on readmission to the facility), and

(IV) regardless of the resident's choice, provide for (or arrange for the provision of) such specialized services[461] for the mental illness or mental retardation.

A State shall not be denied payment under this title for nursing facility services for a resident described in this clause because the resident does not require the level of services provided by such a facility, if the resident chooses to remain in such a facility.

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[458] P.L. 101-508, §4801(b)(4)(B), added clause (iv), effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

[459] P.L. 101-508, §4801(b)(8), struck out "ACTIVE TREATMENT" and substituted "SPECIALIZED SERVICES", effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

[460] P.L. 101-508, §4801(b)(8), struck out "active treatment" and substituted "specialized services", effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

[461] P.L. 101-508, §4801(b)(8), struck out "active treatment" and substituted "specialized services", effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

(ii) OTHER RESIDENTS NOT REQUIRING NURSING FACILITY SERVICES, BUT REQUIRING SPECIALIZED SERVICES[462].—In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require specialized services[463] for mental illness or mental retardation, and who has not continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2),

(II) prepare and orient the resident for such discharge, and

(III) provide for (or arrange for the provision of) such specialized services[464] for the mental illness or mental retardation.

(iii) RESIDENTS NOT REQUIRING NURSING FACILITY SERVICES AND NOT REQUIRING SPECIALIZED SERVICES[465].—In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility and not to require specialized services[466] for mental illness or mental retardation, the State must—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2), and

(II) prepare and orient the resident for such discharge.

(iv) ANNUAL REPORT.—Each State shall report to the Secretary annually concerning the number and disposition of residents described in each of clauses (ii) and (iii).[467]

(D) DENIAL OF PAYMENT[468].—

(i) FOR FAILURE TO CONDUCT PREADMISSION SCREENING OR ANNUAL REVIEW.—[469] No payment may be made under section 1903(a) with respect to nursing facility services furnished to an individual for whom a determination is required under subsection (b)(3)(F) or subparagraph (B) but for whom the determination is not made.[470]

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[462] P.L. 101-508, §4801(b)(8), struck out "ACTIVE TREATMENT" and substituted "SPECIALIZED SERVICES", effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

[463] P.L. 101-508, §4801(b)(8), struck out "active treatment" and substituted "specialized services", effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

[464] P.L. 101-508, §4801(b)(8), struck out "active treatment" and substituted "specialized services", effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

[465] P.L. 101-508, §4801(b)(8), struck out "ACTIVE TREATMENT" and substituted "SPECIALIZED SERVICES", effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

[466] P.L. 101-508, §4801(b)(8), struck out "active treatment" and substituted "specialized services", effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

[467] P.L. 101-508, §4801(b)(5)(A), added clause (iv), effective as if included in the enactment of P.L. 100-203.

See Vol. II, P.L. 100-203, §4215 [as amended by P.L. 101-508, §4801(b)(5)(B)], with respect to the Secretarial report.

[468] P.L. 101-508, §4801(b)(3)(A)(i), struck out "WHERE FAILURE TO CONDUCT PREADMISSION SCREENING", effective as if included in the enactment of P.L. 100-203.

[469] P.L. 101-508, §4801(b)(3)(A)(ii), inserted "(i) FOR FAILURE TO CONDUCT PREADMISSION SCREENING OR ANNUAL REVIEW.—", effective as if included in the enactment of P.L. 100-203.

(ii) For certain residents not requiring nursing facility level of services.—No payment may be made under section 1903(a) with respect to nursing facility services furnished to an individual (other than an individual described in subparagraph (C)(i)) who does not require the level of services provided by a nursing facility.[471]

(E) Permitting alternative disposition plans.—With respect to residents of a nursing facility who are mentally retarded or mentally ill and who are determined under subparagraph (B) not to require the level of services of such a facility, but who require specialized services[472] for mental illness or mental retardation, a State and the nursing facility shall be considered to be in compliance with the requirements of subparagraphs (A) through (C) of this paragraph[473] if, before April 1, 1989, the State and the Secretary have entered into an agreement relating to the disposition of such residents of the facility and the State is in compliance with such agreement. Such an agreement may provide for the disposition of the residents after the date specified in subparagraph (C). The State may revise such an agreement, subject to the approval of the Secretary, before October 1, 1991, but only if, under the revised agreement, all residents subject to the agreement who do not require the level of services of such a facility are discharged from the facility by not later than April 1, 1994.[474]

(F) Appeals procedures.—Each State, as a condition of approval of its plan under this title, effective January 1, 1989, must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (A) or (B).

(G) Definitions.—In this paragraph and in subsection (b)(3)(F):

(i) An individual is considered to be "mentally ill" if the individual has a serious mental illness (as defined by the Secretary in consultation with the National Institute of Mental Health)[475] and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) or a diagnosis (other than a primary diagnosis) of dementia and a primary diagnosis that is not a serious mental illness[476].

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[470] P.L. 101-508, §4801(b)(3)(A)(ii), designated this sentence as clause (i), effective as if included in the enactment of P.L. 100-203.

[471] P.L. 101-508, §4801(b)(3)(A)(iii), added clause (ii), effective as if included in the enactment of P.L. 100-203.

[472] P.L. 101-508, §4801(b)(8), struck out "active treatment" and substituted "specialized services", effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

[473] P.L. 101-508, §4801(b)(3)(B), struck out "the requirement of this paragraph", and substituted "the requirements of subparagraphs (A) through (C) of this paragraph", effective as if included in the enactment of P.L. 100-203.

[474] P.L. 101-508, §4801(b)(6), added this sentence, effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

[475] P.L. 101-508, §4801(b)(7)(A), struck out "primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition)" and substituted "serious mental illness (as defined by the Secretary in consultation with the National Institute of Mental Health)", effective as if included in the enactment of P.L. 100-203.

(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded or a person with a related condition (as described in section 1905(d)).

(iii) The term "specialized services[477]" has the meaning given such term by the Secretary in regulations, but does not include, in the case of a resident of a nursing facility, services within the scope of services which the facility must provide or arrange for its residents under subsection (b)(4).[478]

(f) RESPONSIBILITIES OF SECRETARY RELATING TO NURSING FACILITY REQUIREMENTS.—

(1) GENERAL RESPONSIBILITY.—It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in nursing facilities under State plans approved under this title, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

(2) REQUIREMENTS FOR NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND FOR NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—

(A) IN GENERAL.—For purposes of subsections (b)(5) and (e)(1)(A), the Secretary shall establish, by not later than September 1, 1988—

(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents,[479] basic restorative services, and residents' rights) and[480] content of the curriculum, (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents[481], basic restorative services, and residents' rights, and procedures for determination of competency;

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[476] P.L. 101-508, §4801(b)(7)(B), inserted "or a diagnosis (other than a primary diagnosis) of dementia and a primary diagnosis that is not a serious mental illness", effective as if included in the enactment of P.L. 100-203.

[477] P.L. 101-508, §4801(b)(8), struck out "active treatment" and substituted "specialized services", effective November 5, 1990, without regard to whether or not regulations to implement this amendment have been promulgated.

[478] P.L. 100-203, §4211(a)(3) [as amended by P.L. 100-360, §411(l)(3)(C)(ii) as added by P.L. 100-485, §608(d)(27)(E)], added subsection (e). For the effective date, see Vol. II, P.L. 100-203, §4214.

[479] P.L. 101-239, §6901(b)(3)(A), inserted "care of cognitively impaired residents," applicable to nurse aide training and competency evaluation programs, and nurse aide competency evaluation programs, offered on or after the end of the 90-day period beginning on December 19, 1989, but shall not affect competency evaluations conducted under programs offered before the end of such period.

[480] P.L. 101-239, §6901(d)(4)(C), struck out a comma and substituted "and", effective as if included in the enactment of P.L. 100-203.

(iii) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs; and[482]

(iv) requirements, under both such programs, that—

(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)),[483]

(II) prohibit the imposition on a nurse aide who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program[484] of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program, and[485]

(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a prorata basis during the period in which the nurse aide is so employed.[486]

(B) APPROVAL OF CERTAIN PROGRAMS.—Such requirements—

(i) may permit approval of programs offered by or in facilities, as well as outside facilities (including employee organizations), and of programs in effect on the date of the enactment of this section;

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[481] P.L. 101-239, §6901(b)(3)(B), struck out "cognitive, behavioral and social care" and substituted "recognition of mental health and social service needs, care of cognitively impaired residents", applicable to nurse aide training and competency evaluation programs, and nurse aide competency evaluation programs, offered on or after the end of the 90-day period beginning on December 19, 1989, but shall not affect competency evaluations conducted under programs offered before the end of such period.

[482] P.L. 101-239, §6901(b)(3)(C), struck out the period and substituted "; and".

[483] P.L. 101-508, §4801(a)(5)(A), struck out "and".

[484] P.L. 101-508, §4801(a)(5)(B), inserted "who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program", effective as if included in the enactment of P.L. 100-203.

[485] P.L. 101-239, §6901(b)(3)(D), added clause (iv), applicable to nurse aide training and competency evaluation programs, and nurse aide competency evaluation programs, offered on or after the end of the 90-day period beginning on December 19, 1989, but shall not affect competency evaluations conducted under programs offered before the end of such period.

P.L. 101-503, §4801(a)(5)(C), struck out a period and substituted ", and".

[486] P.L. 101-508, §4801(a)(5)(D), added subclause (III), effective as if included in the enactment of P.L. 100-203.

(ii) shall permit a State to find that an individual who has completed (before July[487] 1, 1989) a nurse aide training and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

(iii) shall prohibit approval of such a program—

(I) offered by or in a nursing facility which, within the previous 2 years—

(a) has operated under a waiver under subsection (b)(4)(C)(ii) that was granted on the basis of a demonstration that the facility is unable to provide the nursing care required under subsection (b)(4)(C)(i) for a period in excess of 48 hours during a week;

(b) has been subject to an extended (or partial extended) survey under section 1819(g)(2)(B)(i) or subsection (g)(2)(B)(i); or

(c) has been assessed a civil money penalty described in section 1819(h)(2)(B)(ii) or subsection (h)(2)(A)(ii) of not less than $5,000, or has been subject to a remedy described in subsection (h)(1)(B)(i), clauses (i), (iii), or (iv) of subsection (h)(2)(A), clauses (i) or (iii) of section 1819(h)(2)(B), or section 1819(h)(4), or[488]

(II) offered by or in a nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in nursing facilities.

A State may not delegate (through subcontract or otherwise)[489] its responsibility under clause (iii)(II) to the nursing facility.[490]

(3) FEDERAL GUIDELINES FOR STATE APPEALS PROCESS FOR TRANSFERS AND DISCHARGES.—For purposes of subsections (c)(2)(B)(iii) and (e)(3), by not later than October 1, 1988, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(3) must meet to provide a fair mechanism for hearing appeals on transfers and discharges of residents from nursing facilities.

(4) SECRETARIAL STANDARDS QUALIFICATION OF ADMINISTRATORS.—For purposes of subsections (d)(1)(C) and (e)(4), the Secretary shall develop, by not later than March 1, 1988, standards to be applied in assuring the qualifications of administrators of nursing facilities.

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[487] P.L. 101-239, §6901(b)(4)(A), struck out "January" and substituted "July", effective as if included in the enactment of P.L. 100-203.

[488] P.L. 101-508, §4801(a)(6)(A), amended subclause (I) in its entirety.

See Vol. II, P.L. 101-508, §4801(a)(6)(B), for the effective date of this amendment. Subclause (I) formerly read as follows:

"(I) offered by or in a nursing facility which has been determined to be out of compliance with the requirements of subsection (b), (c), or (d), within the previous 2 years, or".

[489] P.L. 101-508, §4801(a)(7), inserted "(through subcontract or otherwise)", effective as if included in the enactment of P.L. 100-203.

[490] P.L. 101-239, §6901(b)(2), requires the Secretary to issue proposed regulations to establish the requirements described in this paragraph by not later than March 19, 1990.

(5) Criteria for administration.—The Secretary shall establish criteria for assessing a nursing facility's compliance with the requirement of subsection (d)(1) with respect to—

(A) its governing body and management,

(B) agreements with hospitals regarding transfers of residents to and from the hospitals and to and from other nursing facilities,

(C) disaster preparedness,

(D) direction of medical care by a physician,

(E) laboratory and radiological services,

(F) clinical records, and

(G) resident and advocate participation.

(6) Specification of resident assessment data set and instruments.—The Secretary shall—

(A) not later than January 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3), and establish guidelines for utilization of the data set; and

(B) by not later than April 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii).

(7) List of items and services furnished in nursing facilities not chargeable to the personal funds of a resident.—

(A) Regulations required.—Pursuant to the requirement of section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977[491], the Secretary shall issue regulations, on or before the first day of the seventh month to begin after the date of enactment of this section[492], that define those costs which may be charged to the personal funds of residents in nursing facilities who are individuals receiving medical assistance with respect to nursing facility services under this title and those costs which are to be included in the payment amount under this title for nursing facility services.

(B) Rule if failure to publish regulations.—If the Secretary does not issue the regulations under subparagraph (A) on or before the date required in that subparagraph, in the case of a resident of a nursing facility who is eligible to receive benefits for nursing facility services under this title, for purposes of section 1902(a)(28)(B), the Secretary shall be deemed to have promulgated regulations under this paragraph which provide that the costs which may not be charged to the personal funds of such resident (and for which payment is considered to be made under this title) include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.

(8) Federal minimum criteria and monitoring for preadmission screening and resident review.—

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[491] P.L. 95-142.

[492] December 22, 1987.

(A) MINIMUM CRITERIA.—The Secretary shall develop, by not later than October 1, 1988, minimum criteria for States to use in making determinations under subsections (b)(3)(F) and (e)(7)(B) and in permitting individuals adversely affected to appeal such determinations, and shall notify the States of such criteria.[493]

(B) MONITORING COMPLIANCE.—The Secretary shall review, in a sufficient number of cases to allow reasonable inferences, each State's compliance with the requirements of subsection (e)(7)(C)(ii) (relating to discharge and placement for active treatment of certain residents).

(9) CRITERIA FOR MONITORING STATE WAIVERS.—The Secretary shall develop, by not later than October 1, 1988, criteria and procedures for monitoring State performances in granting waivers pursuant to subsection (b)(4)(C)(ii).[494]

(g) SURVEY AND CERTIFICATION PROCESS.—

(1) STATE AND FEDERAL RESPONSIBILITY.—

(A) IN GENERAL.—Under each State plan under this title, the State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d). The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State nursing facilities with the requirements of such subsections.

(B) EDUCATIONAL PROGRAM.—Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies under this section.

(C) INVESTIGATION OF ALLEGATIONS OF RESIDENT NEGLECT AND ABUSE AND MISAPPROPRIATION OF RESIDENT PROPERTY.—The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority. A

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[493] P.L. 101-239, §6901(c), requires the Secretary to issue proposed regulations to establish the criteria described in this subparagraph by not later than March 19, 1990.

[494] P.L. 100-203, §4211(a)(3) [as amended by P.L. 100-360, §411(l)(3)(C)(ii) as added by P.L. 100-485, §608(d)(27)(E)], added subsection (f). For the effective date, see Vol. II, P.L. 100-203, §4214.

State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.[495]

(D) CONSTRUCTION.—The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(2) SURVEYS.—

(A) ANNUAL STANDARD SURVEY.—

(i) IN GENERAL.—Each nursing facility shall be subject to a standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The Secretary shall review each State's procedures for scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(ii) CONTENTS.—Each standard survey shall include, for a case-mix stratified sample of residents—

(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

(II) written plans of care provided under subsection (b)(2) and an audit of the residents' assessments under subsection (b)(3) to determine the accuracy of such assessments and the adequacy of such plans of care, and

(III) a review of compliance with residents' rights under subsection (c).

(iii) FREQUENCY.—

(I) IN GENERAL.—Each nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this subparagraph. The statewide average interval between standard surveys of a nursing facility shall not exceed 12 months.

(II) SPECIAL SURVEYS.—If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) may be conducted within 2 months of any change of ownership, administration, management of a nursing facility, or director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

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[495] P.L. 101-508, §4801(e)(13), added this sentence, effective as if included in the enactment of P.L. 100-203.

(B) EXTENDED SURVEYS.—

(i) IN GENERAL.—Each nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

(ii) TIMING.—The extended survey shall be conducted immediately after the standard survey (or, if not practicable, not later than 2 weeks after the date of completion of the standard survey).

(iii) CONTENTS.—In such an extended survey, the survey team shall review and identify the policies and procedures which produced such substandard quality of care and shall determine whether the facility has complied with all the requirements described in subsections (b), (c), and (d). Such review shall include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, of in-service training, and, if appropriate, of contracts with consultants.

(iv) CONSTRUCTION.—Nothing in this paragraph shall be construed as requiring an extended or partial extended survey as a prerequisite to imposing a sanction against a facility under subsection (h) on the basis of findings in a standard survey.

(C) SURVEY PROTOCOL.—Standard and extended surveys shall be conducted—

(i) based upon a protocol which the Secretary has developed, tested, and validated by not later than January 1, 1990, and

(ii) by individuals, of a survey team, who meet such minimum qualifications as the Secretary establishes by not later than such date.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

(D) CONSISTENCY OF SURVEYS.—Each State shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

(E) SURVEY TEAMS.—

(i) IN GENERAL.—Surveys under this subsection shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

(ii) PROHIBITION OF CONFLICTS OF INTEREST.—A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d), or who has a personal or familial financial interest in the facility being surveyed.

(iii) TRAINING.—The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys under this subsection, including the auditing of resident assessments and plans of care. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

(3) VALIDATION SURVEYS.—

(A) IN GENERAL.—The Secretary shall conduct onsite surveys of a representative sample of nursing facilities in each State, within 2 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (2). If the State has determined that an individual nursing facility meets the requirements of subsections (b), (c), and (d), but the Secretary determines that the facility does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supersedes that of the State survey.

(B) SCOPE.—With respect to each State, the Secretary shall conduct surveys under subparagraph (A) each year with respect to at least 5 percent of the number of nursing facilities surveyed by the State in the year, but in no case less than 5 nursing facilities in the State.

(C) REDUCTION IN ADMINISTRATIVE COSTS FOR SUBSTANDARD PERFORMANCE.—If the Secretary finds, on the basis of such surveys, that a State has failed to perform surveys as required under paragraph (2) or that a State's survey and certification performance otherwise is not adequate, the Secretary may provide for the training of survey teams in the State and shall provide for a reduction of the payment otherwise made to the State under section 1903(a)(2)(D) with respect to a quarter equal to 33 percent multiplied by a fraction, the denominator of which is equal to the total number of residents in nursing facilities surveyed by the Secretary that quarter and the numerator of which is equal to the total number of residents in nursing facilities which were found pursuant to such surveys to be not in compliance with any of the requirements of subsections (b), (c), and (d). A State that is dissatisfied with the Secretary's findings under this subparagraph may obtain reconsideration and review of the findings under section 1116 in the same manner as a State may seek reconsideration and review under that section of the Secretary's determination under section 1116(a)(1).

(D) Special surveys of compliance.—Where the Secretary has reason to question the compliance of a nursing facility with any of the requirements of subsections (b), (c), and (d), the Secretary may conduct a survey of the facility and, on the basis of that survey, make independent and binding determinations concerning the extent to which the nursing facility meets such requirements.

(4) Investigation of complaints and monitoring nursing facility compliance.—Each State shall maintain procedures and adequate staff to—

(A) investigate complaints of violations of requirements by nursing facilities, and

(B) monitor, on-site, on a regular, as needed basis, a nursing facility's compliance with the requirements of subsections (b), (c), and (d), if—

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against substandard nursing facilities.

(5) Disclosure of results of inspections and activities.—

(A) Public information.—Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys and certifications made respecting nursing facilities, including statements of deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans[496] of correction,

(ii) copies of cost reports of such facilities filed under this title or under title XVIII,

(iii) copies of statements of ownership under section 1124, and

(iv) information disclosed under section 1126.

(B) Notice to ombudsman.—Each State shall notify the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965[497]) of the State's findings of noncompliance with any of the requirements of subsections (b), (c), and (d), or of any adverse action taken against a nursing facility under paragraphs (1), (2), or (3) of subsection (h), with respect[498] to a nursing facility in the State.

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[496] P.L. 101-508, §4801(e)(14), struck out "deficiencies and plans" and substituted "deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans", effective as if included in the enactment of P.L. 100-203.

[497] P.L. 89-73.

[498] P.L. 101-508, §4801(e)(15), struck out "with respect" and substituted "or of any adverse action taken against a nursing facility under paragraphs (1), (2), or (3) of subsection (h), with respect", effective as if included in the enactment of P.L. 100-203.

(C) NOTICE TO PHYSICIANS AND NURSING FACILITY ADMINISTRATOR LICENSING BOARD.—If a State finds that a nursing facility has provided substandard quality of care, the State shall notify—

(i) the attending physician of each resident with respect to which such finding is made, and

(ii) any State board responsible for the licensing of the nursing facility administrator of the facility.

(D) ACCESS TO FRAUD CONTROL UNITS.—Each State shall provide its State medicaid fraud and abuse control unit (established under section 1903(q)) with access to all information of the State agency responsible for surveys and certifications under this subsection.[499]

(h) ENFORCEMENT PROCESS.—

(1) IN GENERAL.—If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) or otherwise, that a nursing facility no longer meets a requirement of subsection (b), (c), or (d), and further finds that the facility's deficiencies—

(A) immediately jeopardize the health or safety of its residents, the State shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in paragraph (2); or

(B) do not immediately jeopardize the health or safety of its residents, the State may—

(i) terminate the facility's participation under the State plan,

(ii) provide for one or more of the remedies described in paragraph (2), or

(iii) do both.

Nothing in this paragraph shall be construed as restricting the remedies available to a State to remedy a nursing facility's deficiencies. If a State finds that a nursing facility meets the requirements of subsections (b), (c), and (d), but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A)(ii) for the days in which it finds that the facility was not in compliance with such requirements.

(2) SPECIFIED REMEDIES.—

(A) LISTING.—Except as provided in subparagraph (B)(ii), each State shall establish by law (whether statute or regulation) at least the following remedies:

(i) Denial of payment under the State plan with respect to any individual admitted to the nursing facility involved after such notice to the public and to the facility as may be provided for by the State.

(ii) A civil money penalty assessed and collected, with interest, for each day in which the facility is or was out of compliance with a requirement of subsection (b), (c), or (d). Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty for activities described in subsections (b)(3)(B)(ii)(I), (b)(3)(B)(ii)(II), or (g)(2)(A)(i)) shall be applied to the protection of the health or property of residents of nursing facilities that the State or the Secretary finds deficient, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost.

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[499] P.L. 100-203, §4212(a), added subsection (g). For the effective date, see Vol. II, P.L. 100-203, §4214.

(iii) The appointment of temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the State has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

(iv) The authority, in the case of an emergency, to close the facility, to transfer residents in that facility to other facilities, or both.

The State also shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the State may provide for other specified remedies, such as directed plans of correction.

(B) DEADLINE AND GUIDANCE.—(i) Except as provided in clause (ii), as a condition for approval of a State plan for calendar quarters beginning on or after October 1, 1989, each State shall establish the remedies described in clauses (i) through (iv) of subparagraph (A) by not later than October 1, 1989. The Secretary shall provide, through regulations by not later than October 1, 1988, guidance to States in establishing such remedies; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedies.

(ii) A State may establish alternative remedies (other than termination of participation) other than those described in clauses (i) through (iv) of subparagraph (A), if the State demonstrates to the Secretary's satisfaction that the alternative remedies are as effective in deterring noncompliance and correcting deficiencies as those described in subparagraph (A).

(C) ASSURING PROMPT COMPLIANCE.—If a nursing facility has not complied with any of the requirements of subsections (b), (c), and (d), within 3 months after the date the facility is found to be out of compliance with such requirements, the State shall impose the remedy described in subparagraph (A)(i) for all individuals who are admitted to the facility after such date.

(D) REPEATED NONCOMPLIANCE.—In the case of a nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2), has been found to have provided substandard quality of care, the State shall (regardless of what other remedies are provided)—

(i) impose the remedy described in subparagraph (A)(i), and

(ii) monitor the facility under subsection (g)(4)(B),

until the facility has demonstrated, to the satisfaction of the State, that it is in compliance with the requirements of subsections (b), (c), and (d), and that it will remain in compliance with such requirements.

(E) FUNDING.—The reasonable expenditures of a State to provide for temporary management and other expenses associated with implementing the remedies described in clauses (iii) and (iv) of subparagraph (A) shall be considered, for purposes of section 1903(a)(7), to be necessary for the proper and efficient administration of the State plan.

(F) INCENTIVES FOR HIGH QUALITY CARE.—In addition to the remedies specified in this paragraph, a State may establish a program to reward, through public recognition, incentive payments, or both, nursing facilities that provide the highest quality care to residents who are entitled to medical assistance under this title. For purposes of section 1903(a)(7), proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this title.

(3) SECRETARIAL AUTHORITY.—

(A) FOR STATE NURSING FACILITIES.—With respect to a State nursing facility, the Secretary shall have the authority and duties of a State under this subsection, including the authority to impose remedies described in clauses (i), (ii), and (iii) of paragraph (2)(A).

(B) OTHER NURSING FACILITIES.—With respect to any other nursing facility in a State, if the Secretary finds that a nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e), and further finds that the facility's deficiencies—

(i) immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (C)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in subparagraph (C); or

(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (C).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a nursing facility's deficiencies. If the Secretary finds that a nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

(C) SPECIFIED REMEDIES.—The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) DENIAL OF PAYMENT.—The Secretary may deny any further payments to the State for medical assistance furnished by the facility to all individuals in the facility or to individuals admitted to the facility after the effective date of the finding.

(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(iii) APPOINTMENT OF TEMPORARY MANAGEMENT.—In consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the Secretary may provide for other specified remedies, such as directed plans of correction.

(D) CONTINUATION OF PAYMENTS PENDING REMEDIATION.—The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the findings[500], under this title with respect to a nursing facility not in compliance with a requirement of subsection (b), (c), or (d), if—

(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility,

(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(iii) the State agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

(4) EFFECTIVE PERIOD OF DENIAL OF PAYMENT.—A finding to deny payment under this subsection shall terminate when the State or Secretary (or both, as the case may be) finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d).

(5) IMMEDIATE TERMINATION OF PARTICIPATION FOR FACILITY WHERE STATE OR SECRETARY FINDS NONCOMPLIANCE AND IMMEDIATE JEOPARDY.—If either the State or the Secretary finds that a nursing facility has not met a requirement of subsection (b), (c), or (d), and finds that the failure immediately jeopardizes the health or safety of its residents, the State or the Secretary, respectively shall notify the other of such finding, and the State or the Secretary, respectively, shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii) or (3)(C)(iii), or terminate the facility's participation under the State plan. If the facility's participation in the State plan is terminated by either the State or the Secretary, the State shall provide for the safe and orderly transfer of the residents eligible under the State plan consistent with the requirements of subsection (c)(2).

(6) SPECIAL RULES WHERE STATE AND SECRETARY DO NOT AGREE ON FINDING OF NONCOMPLIANCE.—

(A) STATE FINDING OF NONCOMPLIANCE AND NO SECRETARIAL FINDING OF NONCOMPLIANCE.—If the Secretary finds that a nursing facility has met all the requirements of subsections (b), (c), and (d), but a State finds that the facility has not met such requirements and the failure does not immediately jeopardize the health or safety of its residents, the State's findings shall control and the remedies imposed by the State shall be applied.

(B) SECRETARIAL FINDING OF NONCOMPLIANCE AND NO STATE FINDING OF NONCOMPLIANCE.—If the Secretary finds that a nursing facility has not met all the requirements of subsections (b), (c), and (d), and that the failure does not immediately jeopardize the health or safety of its residents, but the State has not made such a finding, the Secretary—

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[500] P.L. 101-239, §6901(d)(4)(D), inserted "after the effective date of the findngs", effective as if included in the enactment of P.L. 100-203.

(i) may impose any remedies specified in paragraph (3)(C) with respect to the facility, and

(ii) shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D).

(7) SPECIAL RULES FOR TIMING OF TERMINATION OF PARTICIPATION WHERE REMEDIES OVERLAP.—If both the Secretary and the State find that a nursing facility has not met all the requirements of subsections (b), (c), and (d), and neither finds that the failure immediately jeopardizes the health or safety of its residents—

(A)(i) if both find that the facility's participation under the State plan should be terminated, the State's timing of any termination shall control so long as the termination date does not occur later than 6 months after the date of the finding to terminate;

(ii) if the Secretary, but not the State, finds that the facility's participation under the State plan should be terminated, the Secretary shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D); or

(iii) if the State, but not the Secretary, finds that the facility's participation under the State plan should be terminated, the State's decision to terminate, and timing of such termination, shall control; and

(B)(i) if the Secretary or the State, but not both, establishes one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, such additional or alternative remedies shall also be applied, or

(ii) if both the Secretary and the State establish one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, only the additional or alternative remedies of the Secretary shall apply.

(8) CONSTRUCTION.—The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (iii), and (iv) of paragraph (2)(A) may be imposed during the pendency of any hearing. The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of title XVIII.[501]

(9) SHARING OF INFORMATION.—Notwithstanding any other provision of law, all information concerning nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such facilities to Federal or State employees for purposes consistent with the effective admin-

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[501] P.L. 101-239, §6901(d)(1), added this sentence, effective December 19, 1989.

istration of programs established under this title and title XVIII, including investigations by State medicaid fraud control units.[502]

(i) CONSTRUCTION.—Where requirements or obligations under this section are identical to those provided under section 1819 of this Act, the fulfillment of those requirements or obligations under section 1819 shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN

SEC. 1920. [42 U.S.C. 1396r-1] (a) A State plan approved under section 1902 may provide for making ambulatory prenatal care available to a pregnant woman during a presumptive eligibility period.

(b) For purposes of this section—

(1) the term "presumptive eligibility period" means, with respect to a pregnant woman, the period that—

(A) begins with the date on which a qualified provider determines, on the basis of preliminary information, that the family income of the woman does not exceed the applicable income level of eligibility under the State plan, and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of the woman for medical assistance under the State plan, or[503]

(ii) in the case of a woman who does not file an application by the last day of the month following the month during which the provider makes the determination referred to in subparagraph (A), such last day; and[504]

(2) the term "qualified provider" means any provider that—

(A) is eligible for payments under a State plan approved under this title,

(B) provides services of the type described in subparagraph (A) or (B) of section 1905(a)(2) or in section 1905(a)(9),

(C) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A), and

(D)(i) receives funds under—

(I) section 329, 330, or 340 of the Public Health Service Act[505],

(II) title V of this Act, or

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[502] P.L. 100-203, §4213(a), added subsection (h). For the effective date, see Vol. II, P.L. 100-203, §4214.

[503] P.L. 101-508, §4605(a)(1)(A), added "or".

[504] P.L. 101-508, §4605(a)(1)(B), struck out clause (ii), applicable to payments under title XIX for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date. Until then, clause (ii) continues to read as follows:

"(ii) the day that is 45 days after the date on which the provider makes the determination referred to in subparagraph (A), or".

P.L. 101-508, §4605(a)(1)(C), redesignated clause (iii) as clause (ii) and amended it in its entirety, applicable to payments under title XIX for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date. Until then, clause (iii) continues to read as follows:

"(iii) in the case of a woman who does not file an application for medical assistance within 14 calendar days after the date on which the provider makes the determination referred to in subparagraph (A), the fourteenth calendar day after such determination is made; and".

[505] P.L. 78-410.

(III) title V of the Indian Health Care Improvement Act[506];

(ii) participates in a program established under—

(I) section 17 of the Child Nutrition Act of 1966[507], or

(II) section 4(a) of the Agriculture and Consumer Protection Act of 1973[508];

(iii) participates in a State perinatal program; or

(iv) is the Indian Health Service or is a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638).

(c)(1) The State agency shall provide qualified providers with—

(A) such forms as are necessary for a pregnant woman to make application for medical assistance under the State plan, and

(B) information on how to assist such women in completing and filing such forms.

(2) A qualified provider that determines under subsection (b)(1)(A) that a pregnant woman is presumptively eligible for medical assistance under a State plan shall—

(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

(B) inform the woman at the time the determination is made that she is required to make application for medical assistance under the State plan by not later than the last day of the month following the month during which[509] the determination is made.

(3) A pregnant woman who is determined by a qualified provider to be presumptively eligible for medical assistance under a State plan shall make application for medical assistance under such plan by not later than the last day of the month following the month during which[510] the determination is made, which application may be the application used for the receipt of medical assistance by individuals described in section 1902(l)(1)(A)[511].

(d) Notwithstanding any other provision of this title, ambulatory prenatal care that—

(1) is furnished to a pregnant woman—

(A) during a presumptive eligibility period,

(B) by a provider that is eligible for payments under the State plan; and

(2) is included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1903.

INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS AND PROVIDERS

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[506] P.L. 94-437.

[507] P.L. 89-642.

[508] P.L. 93-86.

[509] P.L. 101-508, §4605(a)(2), struck out "within 14 calendar days after the date on which" and substituted "by not later than the last day of the month following the month during which", applicable to payments under title XIX for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

[510] P.L. 101-508, §4605(a)(2), struck out "within 14 calendar days after the date on which" and substituted "by not later than the last day of the month following the month during which", applicable to payments under title XIX for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

[511] P.L. 101-508, §4605(b), inserted ", which application may be the application used for the receipt of medical assistance by individuals described in section 1902(l)(1)(A)", effective as if included in the enactment of P.L. 99-509, §9407(b).

Sec. 1921. [42 U.S.C. 1396r-2] (a) Information Reporting Requirement.—The requirement referred to in section 1902(a)(49) is that the State must provide for the following:

(1) Information reporting system.—The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by any authority of the State (or of a political subdivision thereof) responsible for the licensing of health care practitioners (or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners)[512] or entities:

(A) Any adverse action taken by such licensing authority as a result of the proceeding, including any revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation.

(B) Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction.

(C) Any other loss of the license of the practitioner or entity, whether by operation of law, voluntary surrender, or otherwise.

(D) Any negative action or finding by such authority, organization, or entity regarding the practitioner or entity.[513]

(2) Access to documents.—The State must provide the Secretary (or an entity designated by the Secretary) with access to such documents of the authority described in paragraph (1) as may be necessary for the Secretary to determine the facts and circumstances concerning the actions and determinations described in such paragraph for the purpose of carrying out this Act.

(b) Form of Information.—The information described in subsection (a)(1) shall be provided to the Secretary (or to an appropriate private or public agency, under suitable arrangements made by the Secretary with respect to receipt, storage, protection of confidentiality, and dissemination of information) in such a form and manner as the Secretary determines to be appropriate in order to provide for activities of the Secretary under this Act and in order to provide, directly or through suitable arrangements made by the Secretary, information—

(1) to agencies administering Federal health care programs, including private entities administering such programs under contract,

(2) to licensing authorities described in subsection (a)(1),

(3) to State agencies administering or supervising the administration of State health care programs (as defined in section 1128(h)),

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[512] P.L. 101-508, §4752(f)(1)(A), inserted "(or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners)", applicable to State information reporting systems as of January 1, 1992, without regard to whether or not the Secretary has promulgated any regulations to carry out this amendment by such date.

[513] P.L. 101-508, §4752(f)(1)(B), added subparagraph (D), applicable to State information reporting systems as of January 1, 1992, without regard to whether or not the Secretary has promulgated any regulations to carry out this amendment by such date.

(4) to utilization and quality control peer review organizations described in part B of title XI and to appropriate entities with contracts under section 1154(a)(4)(C) with respect to eligible organizations reviewed under the contracts,

(5) to State medicaid fraud control units (as defined in section 1903(q)),

(6) to hospitals and other health care entities (as defined in section 431 of the Health Care Quality Improvement Act of 1986[514]), with respect to physicians or other licensed health care practitioners that have entered (or may be entering) into an employment or affiliation relationship with, or have applied for clinical privileges or appointments to the medical staff of, such hospitals or other health care entities (and such information shall be deemed to be disclosed pursuant to section 427 of, and be subject to the provisions of, that Act),

(7) to the Attorney General and such other law enforcement officials as the Secretary deems appropriate, and

(8) upon request, to the Comptroller General,

in order for such authorities to determine the fitness of individuals to provide health care services, to protect the health and safety of individuals receiving health care through such programs, and to protect the fiscal integrity of such programs.

(c) CONFIDENTIALITY OF INFORMATION PROVIDED.—The Secretary shall provide for suitable safeguards for the confidentiality of the information furnished under subsection (a). Nothing in this subsection shall prevent the disclosure of such information by a party which is otherwise authorized, under applicable State law, to make such disclosure.

(d) APPROPRIATE COORDINATION.—The Secretary shall provide for the maximum appropriate coordination in the implementation of subsection (a) of this section and section 422 of the Health Care Quality Improvement Act of 1986.

CORRECTION AND REDUCTION PLANS FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED[515]

SEC. 1922[516]. [42 U.S.C. 1396r-3] (a) If the Secretary finds that an intermediate care facility for the mentally retarded has substantial deficiencies which do not pose an immediate threat to the health and safety of residents (including failure to provide active treatment), the State may elect, subject to the limitations in this section, to—

(1) submit, within the number of days specified by the Secretary in regulations which apply to submission of compliance plans with respect to deficiencies of such type, a written plan of correction which details the extent of the facility's current compliance with the standards promulgated by the Secretary, including all deficiencies identified during a validation survey, and which provides for a timetable for completion of necessary steps to correct all staffing deficiencies within 6 months, and a timetable for rectifying all physical plant deficiencies within 6 months; or

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[514] P.L. 99-660, Title IV.

[515] See Vol. II, P.L. 99-272, §9516(c), with respect to a report to Congress regarding the implementation and results of this section .

See Vol. II, P.L. 100-203, §4217, with respect to regulations.

[516] P.L. 100-203, §4211(a)(2), redesignated the former §1919 as §1922. For the effective date, see Vol. II, P.L. 100-203, §4214 .

(2) submit, within a time period consisting of the number of days specified for submissions under paragraph (1) plus 35 days, a written plan for permanently reducing the number of certified beds, within a maximum of 36 months, in order to permit any noncomplying buildings (or distinct parts thereof) to be vacated and any staffing deficiencies to be corrected (hereinafter in this section referred to as a "reduction plan").

(b) As conditions of approval of any reduction plan submitted pursuant to subsection (a)(2), the State must—

(1) provide for a hearing to be held at the affected facility at least 35 days prior to submission of the reduction plan, with reasonable notice thereof to the staff and residents of the facility, responsible members of the residents' families, and the general public;

(2) demonstrate that the State has successfully provided home and community services similar to the services proposed to be provided under the reduction plan for similar individuals eligible for medical assistance; and

(3) provide assurances that the requirements of subsection (c) shall be met with respect to the reduction plan.

(c) The reduction plan must—

(1) identify the number and service needs of existing facility residents to be provided home or community services and the timetable for providing such services, in 6 month intervals, within the 36-month period;

(2) describe the methods to be used to select such residents for home and community services and to develop the alternative home and community services to meet their needs effectively;

(3) describe the necessary safeguards that will be applied to protect the health and welfare of the former residents of the facility who are to receive home or community services, including adequate standards for consumer and provider participation and assurances that applicable State licensure and applicable State and Federal certification requirements will be met in providing such home or community services;

(4) provide that residents of the affected facility who are eligible for medical assistance while in the facility shall, at their option, be placed in another setting (or another part of the affected facility) so as to retain their eligibility for medical assistance;

(5) specify the actions which will be taken to protect the health and safety of, and to provide active treatment for, the residents who remain in the affected facility while the reduction plan is in effect;

(6) provide that the ratio of qualified staff to residents at the affected facility (or the part thereof) which is subject to the reduction plan will be the higher of—

(A) the ratio which the Secretary determines is necessary in order to assure the health and safety of the residents of such facility (or part thereof); or

(B) the ratio which was in effect at the time that the finding of substantial deficiencies (referred to in subsection (a)) was made; and

(7) provide for the protection of the interests of employees affected by actions under the reduction plan, including—

(A) arrangements to preserve employee rights and benefits;

(B) training and retraining of such employees where necessary;

(C) redeployment of such employees to community settings under the reduction plan; and

(D) making maximum efforts to guarantee the employment of such employees (but this requirement shall not be construed to guarantee the employment of any employee).

(d)(1) The Secretary must provide for a period of not less than 30 days after the submission of a reduction plan by a State, during which comments on such reduction plan may be submitted to the Secretary, before the Secretary approves or disapproves such reduction plan.

(2) If the Secretary approves more than 15 reduction plans under this section in any fiscal year, any reduction plans approved in addition to the first 15 such plans approved, must be for a facility (or part thereof) for which the costs of correcting the substantial deficiencies (referred to in subsection (a)) are $2,000,000 or greater (as demonstrated by the State to the satisfaction of the Secretary).

(e)(1) If the Secretary, at the conclusion of the 6-month plan of correction described in subsection (a)(1), determines that the State has substantially failed to correct the deficiencies described in subsection (a), the Secretary may terminate the facility's provider agreement in accordance with the provisions of section 1910(b)[517].

(2) In the case of a reduction plan described in subsection (a)(2), if the Secretary determines, at the conclusion of the initial 6-month period or any 6-month interval thereafter, that the State has substantially failed to meet the requirements of subsection (c), the Secretary shall—

(A) terminate the facility's provider agreement in accordance with the provisions of section 1910(b)[518]; or

(B) if the State has failed to meet such requirements despite good faith efforts, disallow, for purposes of Federal financial participation, an amount equal to 5 percent of the cost of care for all eligible individuals in the facility for each month for which the State fails to meet such requirements.

(f) The provisions of this section shall apply only to plans of correction and reduction plans approved by the Secretary by January 1, 1990.

ADJUSTMENT IN PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED BY DISPROPORTIONATE SHARE HOSPITALS

SEC. 1923. [42 U.S.C. 1396r-4] (a) IMPLEMENTATION OF REQUIREMENT.—

(1) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(13)(A) (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State

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[517] P.L. 100-203, §4212(e)(5) [as added by P.L. 100-360, §411(l)(6)(E)], struck out "1910(c)" and substituted "1910(b)". For the effective date, see Vol. II, P.L. 100-203, §4214.

[518] P.L. 100-203, §4212(e)(5) [as added by P.L. 100-360, §411(l)(6)(E)], struck out "1910(c)" and substituted "1910(b)". For the effective date, see Vol. II, P.L. 100-203, §4214.

has submitted to the Secretary, by not later than such date, an amendment to such plan that—

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) which meets the requirement of subsection (d)), and

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c).

(2)(A) In order to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, the State plan amendment described in paragraph (1), consistent with subsection (c), effective for inpatient hospital services provided on or after July 1, 1989.

(B) In order to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1990, the State must submit to the Secretary by not later than April 1, 1990, the State plan amendment described in paragraph (1), consistent with subsection (c), effective for inpatient hospital services provided on or after July 1, 1990.

(C) If a State plan under this title provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.

(3) The Secretary shall, not later than 90 days after the date a State submits an amendment under this subsection, review each such amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

(4) The requirement of this subsection may not be waived under section 1915(b)(4).

(b) Hospitals Deemed Disproportionate Share.—

(1) For purposes of subsection (a)(1), a hospital which meets the requirement of subsection (d) is deemed to be a disproportionate share hospital if—

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this title in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.[519]

(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of—

(A) the fraction (expressed as a percentage)—

(i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this title and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

(B) a fraction (expressed as a percentage)—

(i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approved under this title).

(c) PAYMENT ADJUSTMENT.—In order to be consistent with this subsection, a payment adjustment for a disproportionate share hospital must either—

(1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind described in section 1886(a)(4)), and (B) the hospital's disproportionate share adjustment percentage (established under section 1886(d)(5)(F)(iv));[520]

(2) provide for a minimum specified additional payment amount (or increased percentage payment) and (without regard to whether the hospital is described in subparagraph (A) or (B) of subsection (b)(1)) for an increase in such a payment amount (or

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[519] P.L. 101-508, §4702(a), added this sentence, effective July 1, 1990.

[520] P.L. 101-508, §4703(a)(1), struck out "or".

percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate (as defined in subsection (b)(2)) exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State or the hospital's low-income utilization rate (as defined in paragraph (b)(3))[521]; or[522]

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that—

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this title or to low-income patients.[523]

except that, for purposes of paragraphs (1)(B) and (2)(A) of subsection (a), the payment adjustment for a disproportionate share hospital is consistent with this subsection if the appropriate increase in the rate or amount of payment is equal to at least one-third of the increase otherwise applicable under this subsection (in the case of such paragraph (1)(B)) and at least two-thirds of such increase (in the case of such paragraph (2)(A)). In the case of a hospital described in subsection (d)(2)(A)(i) (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in section 1886(d)(5)(F)(vi)) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital.

(d) REQUIREMENT TO QUALIFY AS DISPROPORTIONATE SHARE HOSPITAL.—

(1) Except as provided in paragraph (2), no hospital may be defined or deemed as a disproportionate share hospital under a State plan under this title or under subsection (b) of this section unless the hospital has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

(2)(A) Paragraph (1) shall not apply to a hospital—

(i) the inpatients of which are predominantly individuals under 18 years of age; or

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[521] P.L. 101-508, §4703(c), inserted "or the hospital's low-income utilization rate (as defined in paragraph (b)(3))", effective as if included in the enactment of P.L. 100-203, "section 412(a)(2)". Probably should be "section 4112(a)(2)".

[522] P.L. 101-508, §4703(a)(2), added "or".

[523] P.L. 101-508, §4703(a)(3), added paragraph (3), effective as if included in the enactment of P.L. 100-203, "section 412(a)(2)". Probably should be "section 4112(a)(2)". Punctuation at end of subparagraph (B) as in original.

(ii) which does not offer nonemergency obstetric services to the general population as of the date of the enactment of this Act[524].

(B) In the case of a hospital located in a rural area (as defined for purposes of section 1886), in paragraph (1) the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(e) SPECIAL RULE.—(1) A State plan shall be considered to meet the requirement of section 1902(a)(13)(A) (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs) without regard to the requirement of subsection (a) if (A)(i)[525] the plan provided for payment adjustments based on a pooling arrangement involving a majority of the hospitals participating under the plan for disproportionate share hospitals as of January 1, 1984, or (ii) the plan as of January 1, 1987, provided for payment adjustments based on a statewide pooling arrangement involving all acute care hospitals and the arrangement provides for reimbursement of the total amount of uncompensated care provided by each participating hospital, and (B)[526] the aggregate amount of the payment adjustments under the plan for such hospitals is not less than the aggregate amount of such adjustments otherwise required to be made under such subsection.

(2) In the case of a State that used a health insuring organization before January 1, 1986, to administer a portion of its plan on a statewide basis,[527] beginning on July 1, 1988—

(A) the requirements of subsections (b) and (c) shall not apply if the aggregate amount of the payment adjustments under the plan for disproportionate share hospitals (as defined under the State plan) is not less than the aggregate amount of payment adjustments otherwise required to be made if such subsections applied, and

(B) subsection (d)(2)(B) shall apply to hospitals located in urban areas, as well as in rural areas.

TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES[528]

SEC. 1924. [42 U.S.C. 1396r-5] (a) SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.—

(1) SUPERSEDES OTHER PROVISIONS.—In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (h)(1)), the provisions of this section supersede any other provision of this title (including sections 1902(a)(17) and 1902(f)) which is inconsistent with them.

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[524] December 22, 1987.

[525] P.L. 101-239, §6411(c)(1)(A), inserted "(A)(i)", effective December 19, 1989.

[526] P.L. 101-239, §6411(c)(1)(B), struck out "and if" and substituted "or", clause (ii), and "(B)", effective December 19, 1989.

[527] P.L. 101-508, §§4703(b), struck out "during the 3-year period", effective as if included in the enactment of P.L. 100-203, §412(a)(2)*.

*Probably should be §4112(a)(2).

[528] P.L. 100-360, §303(a)(1)(B), added this §1924, only applicable to institutionalized individuals who begin continuous periods of institutionalization on or after September 30, 1989, except that subsections (b) and (d) of this section (and so much of subsection (e) as relates to subsections (b) and (d)) shall apply as of September 30, 1989, to individuals institutionalized on or after September 30, 1989.

See Vol. II, P.L. 99-509, §9412(b)(4) [as added by P.L. 101-508, §4744(b)(2)], with respect to certain waivers.

(2) No comparable treatment required.—Any different treatment provided under this section for institutionalized spouses shall not, by reason of paragraph (10) or (17) of section 1902(a), require such treatment for other individuals.

(3) Does not affect certain determinations.—Except as this section specifically provides, this section does not apply to—

(A) the determination of what constitutes income or resources, or

(B) the methodology and standards for determining and evaluating income and resources.

(4) Application in certain states and territories.—

(A) Application in states operating under demonstration projects.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

(B) No application in commonwealths and territories.—This section shall only apply to a State that is one of the 50 States or the District of Columbia.

(5) Application to individuals receiving services from organizations receiving certain waivers.—This section applies to individuals receiving institutional or noninstitutional services from any organization receiving a frail elderly demonstration project waiver under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986.[529]

(b) Rules for Treatment of Income.—

(1) Separate treatment of income.—During any month in which an institutionalized spouse is in the institution, except as provided in paragraph (2), no income of the community spouse shall be deemed available to the institutionalized spouse.

(2) Attribution of income.—In determining the income of an institutionalized spouse or community spouse for purposes of the post-eligibility income determination described in subsection (d)[530], except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

(A) Non-trust property.—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

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[529] P.L. 101-508, §4744(b)(1), added paragraph (5), effective November 5, 1990.

[530] P.L. 101-508, §4714(a), struck out ", after the institutionalized spouse has been determined or redetermined[*] to be eligible for medical assistance" and substituted "for purposes of the post-eligibility income determination described in subsection (d)", effective as if included in the enactment of P.L. 100-360, §303.

[*] P.L. 101-239, §6411(e)(3), inserted "or redetermined", applicable as if included in the enactment of P.L. 100-360, §303.

(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

(B) TRUST PROPERTY.—In the case of a trust—

(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this title (including sections 1902(a)(17) and 1902(k)), and

(ii) income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust—

(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(II) if payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

(C) PROPERTY WITH NO INSTRUMENT.—In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.

(D) REBUTTING OWNERSHIP.—The rules of subparagraphs (A) and (C) are superseded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

(c) RULES FOR TREATMENT OF RESOURCES.—

(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—

(A) TOTAL JOINT RESOURCES.—There shall be computed (as of the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989)[531] of the institutionalized spouse)—

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[531] P.L. 101-508, §4714(c), struck out "a continuous period of institutionalization" and substituted "the first continuous period of institutionalization (beginning on or after September 30, 1989)", effective as if included in the enactment of P.L. 100-360, §303.

(i) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest, and

(ii) a spousal share which is equal to 1/2 of such total value.

(B) ASSESSMENT.—At the request of an institutionalized spouse or community spouse, at the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989)[532] of the institutionalized spouse and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for medical assistance under this title, the State may, at its option as a condition of providing the assessment, require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment. At the time of providing the copy of the assessment, the State shall include a notice indicating that the spouse will have a right to a fair hearing under subsection (e)(2).

(2) ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.—In determining the resources of an institutionalized spouse at the time of application for benefits under this title, regardless of any State laws relating to community property or the division of marital property—

(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

(B) resources shall be considered to be available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds the amount computed under subsection (f)(2)(A) (as of the time of application for benefits).

(3) ASSIGNMENT OF SUPPORT RIGHTS.—The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—

(A) the institutionalized spouse has assigned to the State any rights to support from the community spouse;

(B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment; or

(C) the State determines that denial of eligibility would work an undue hardship.

(4) SEPARATE TREATMENT OF RESOURCES AFTER ELIGIBILITY FOR BENEFITS ESTABLISHED.—During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be

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[532] P.L. 101-508, §4714(c), struck out "a continuous period of institutionalization" and substituted "the first continuous period of institutionalization (beginning on or after September 30, 1989)", effective as if included in the enactment of P.L. 100-360, §303.

eligible for benefits under this title, no resources of the community spouse shall be deemed available to the institutionalized spouse.

(5) RESOURCES DEFINED.—In this section, the term "resources" does not include—

(A) resources excluded under subsection (a) or (d) of section 1613, and

(B) resources that would be excluded under section 1613(a)(2)(A) but for the limitation on total value described in such section.

(d) PROTECTING INCOME FOR COMMUNITY SPOUSE.—

(1) ALLOWANCES TO BE OFFSET FROM INCOME OF INSTITUTIONALIZED SPOUSE.—After an institutionalized spouse is determined or redetermined[533] to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

(A) A personal needs allowance (described in section 1902(q)(1)), in an amount not less than the amount specified in section 1902(q)(2).

(B) A community spouse monthly income allowance (as defined in paragraph (2)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

(C) A family allowance, for each family member, equal to at least 1/3 of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the monthly income of that family member.

(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse (as provided under section 1902(r)).

In subparagraph (C), the term "family member" only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

(2) COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE DEFINED.—In this section (except as provided in paragraph (5)), the "community spouse monthly income allowance" for a community spouse is an amount by which—

(A) except as provided in subsection (e), the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (3)) for the spouse, exceeds

(B) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

(3) ESTABLISHMENT OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—

(A) IN GENERAL.—Each State shall establish a minimum monthly maintenance needs allowance for each community spouse which, subject to subparagraph (C), is equal to or exceeds—

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[533] P.L. 101-239, §6411(e)(3), inserted "or redetermined", applicable as if included in the enactment of P.L. 100-360, §303.

(i) the applicable percent (described in subparagraph (B)) of 1/12 of the income official poverty line (defined by the Office of Management and Budget and revised annually in accordance with sections 652 and 673(2) of the Omnibus Budget Reconciliation Act of 1981[534]) for a family unit of 2 members; plus

(ii) an excess shelter allowance (as defined in paragraph (4)).

A revision of the official poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

(B) APPLICABLE PERCENT.—For purposes of subparagraph (A)(i), the "applicable percent" described in this paragraph, effective as of—

(i) September 30, 1989, is 122 percent,

(ii) July 1, 1991, is 133 percent, and

(iii) July 1, 1992, is 150 percent.

(C) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed $1,500 (subject to adjustment under subsections (e) and (g)).

(4) EXCESS SHELTER ALLOWANCE DEFINED.—In paragraph (3)(A)(ii), the term "excess shelter allowance" means, for a community spouse, the amount by which the sum of—

(A) the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge, for the community spouse's principal residence, and

(B) the standard utility allowance (used by the State under section 5(e) of the Food Stamp Act of 1977[535]) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

(5) COURT ORDERED SUPPORT.—If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

(e) NOTICE AND FAIR HEARING.—

(1) NOTICE.—Upon—

(A) a determination of eligibility for medical assistance of an institutionalized spouse, or

(B) a request by either the institutionalized spouse, or the community spouse, or a representative acting on behalf of either spouse, each State shall notify both spouses (in the case described in subparagraph (A)) or the spouse making the request (in the case described in subparagraph (B)) of the amount of the community spouse monthly income allowance (described in subsection (d)(1)(B)), of the amount of any family allowances (described in subsection (d)(1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (f), and of the spouse's right to a fair hearing under this subsection respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

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[534] See Vol. II, P.L. 97-35, §§652 and 673(2).

[535] P.L. 88-525.

(2) FAIR HEARING.—

(A) IN GENERAL.—If either the institutionalized spouse or the community spouse is dissatisfied with a determination of—

(i) the community spouse monthly income allowance;

(ii) the amount of monthly income otherwise available to the community spouse (as applied under subsection (d)(2)(B));

(iii) the computation of the spousal share of resources under subsection (c)(1);

(iv) the attribution of resources under subsection (c)(2); or

(v) the determination of the community spouse resource allowance (as defined in subsection (f)(2));

such spouse is entitled to a fair hearing described in section 1902(a)(3) with respect to such determination if an application for benefits under this title has been made on behalf of the institutionalized spouse. Any such hearing respecting the determination of the community spouse resource allowance shall be held within 30 days of the date of the request for the hearing.

(B) REVISION OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—If either such spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in subsection (d)(2)(A), an amount adequate to provide such additional income as is necessary.

(C) REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE.—If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.

(f) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—

(1) IN GENERAL.—An institutionalized spouse may, without regard to section 1917(c)(1)[536], transfer an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse. The transfer under the preceding sentence shall be made as soon as practicable after the date of the initial determination of eligibility, taking into account such time as may be necessary to obtain a court order under paragraph (3).

(2) COMMUNITY SPOUSE RESOURCE ALLOWANCE DEFINED.—In paragraph (1), the "community spouse resource allowance" for a community spouse is an amount (if any) by which—

(A) the greatest of—

(i) $12,000 (subject to adjustment under subsection (g)), or, if greater (but not to exceed the amount specified in clause (ii)(II)) an amount specified under the State plan,

(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) $60,000 (subject to adjustment under subsection (g)),

(iii) the amount established under subsection (e)(2); or

(iv) the amount transferred under a court order under paragraph (3);

exceeds

(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

(3) TRANSFERS UNDER COURT ORDERS.—If a court has entered an order against an institutionalized spouse for the support of the community spouse, section 1917 shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse or a family member (as defined in subsection (d)(1)).

(g) INDEXING DOLLAR AMOUNTS.—For services furnished during a calendar year after 1989, the dollar amounts specified in subsections (d)(3)(C), (f)(2)(A)(i), and (f)(2)(A)(ii)(II) shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the calendar year involved.

(h) DEFINITIONS.—In this section:

(1) The term "institutionalized spouse" means an individual who—

(A) is in a medical institution or nursing facility or who (at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI), and

(B) is married to a spouse who is not in a medical institution or nursing facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

(2) The term "community spouse" means the spouse of an institutionalized spouse.

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[536] P.L. 101-508, §4714(b), struck out "1917" and substituted "1917(c)(1)", effective as if included in the enactment of P.L. 100-360, §303.

EXTENSION OF ELIGIBILITY FOR MEDICAL ASSISTANCE[537]

SEC. 1925. [42 U.S.C. 1396r-6] (a) INITIAL 6-MONTH EXTENSION.—

(1) REQUIREMENT.—Notwithstanding any other provision of this title, each State plan approved under this title must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of title IV in at least 3 of the 6 months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of, or income from, employment of the caretaker relative (as defined in subsection (e)) or because of section 402(a)(8)(B)(ii)(II) (providing for a time-limited earned income disregard), shall, subject to paragraph (3) and without any reapplication for benefits under the plan, remain eligible for assistance under the plan approved under this title during the immediately succeeding 6-month period in accordance with this subsection.

(2) NOTICE OF BENEFITS.—Each State, in the notice of termination of aid under part A of title IV sent to a family meeting the requirements of paragraph (1)—

(A) shall notify the family of its right to extended medical assistance under this subsection and include in the notice a description of the reporting requirement of subsection (b)(2)(B)(i) and of the circumstances (described in paragraph (3)) under which such extension may be terminated; and

(B) shall include a card or other evidence of the family's entitlement to assistance under this title for the period provided in this subsection.

(3) TERMINATION OF EXTENSION.—

(A) NO DEPENDENT CHILD.—Subject to subparagraphs (B) and (C), extension of assistance during the 6-month period described in paragraph (1) to a family shall terminate (during such period) at the close of the first month in which the family ceases to include a child, whether or not the child[538] is (or would if needy be) a dependent child under part A of title IV.

(B) NOTICE BEFORE TERMINATION.—No termination of assistance shall become effective under subparagraph (A) until the State has provided the family with notice of the grounds for the termination.

(C) CONTINUATION IN CERTAIN CASES UNTIL REDETERMINATION.—With respect to a child who would cease to receive medical assistance because of subparagraph (A) but who may be eligible for assistance under the State plan because the child is described in clause (i) of section 1905(a) or clause (i)(IV), (i)(VI) (i)(VII),[539], or (ii)(IX) of section

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[537] P.L. 100-485, §303(a)(1), added this §1925, applicable to payments under this title for calendar quarters beginning on or after April 1, 1990 (or, in the case of the Commonwealth of Kentucky, October 1, 1990) (without regard to whether regulations to implement this amendment are promulgated by such date), with respect to families that cease to be eligible for aid under part A of title IV on or after such date.

See Vol. II, P.L. 100-485, §303(c), with respect to a study of the impact of medicaid extension provisions.

[538] P.L. 101-239, §6411(i)(1), struck out "who" and substituted ", whether or not the child", effective as if included in the enactment of P.L. 100-485.

[539] P.L. 101-508, §4601(a)(3)(B), inserted "(i)(VII)," after "(VI)"*, applicable (except as otherwise provided in Vol. II, P.L. 100-508, §4601(b)(2)) to payments under title XIX for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date. *As in original; "(VI)" should probably read "(VI),".

1902(a)(10)(A)[540], the State may not discontinue such assistance under such subparagraph until the State has determined that the child is not eligible for assistance under the plan.

(4) Scope of coverage.—

(A) In general.—Subject to subparagraph (B), during the 6-month extension period under this subsection, the amount, duration, and scope of medical assistance made available with respect to a family shall be the same as if the family were still receiving aid under the plan approved under part A of title IV.

(B) State medicaid "wrap-around" option.—A State, at its option, may pay a family's expenses for premiums, deductibles, coinsurance, and similar costs for health insurance or other health coverage offered by an employer of the caretaker relative or by an employer of the absent parent of a dependent child. In the case of such coverage offered by an employer of the caretaker relative—

(i) the State may require the caretaker relative, as a condition of extension of coverage under this subsection for the caretaker and the caretaker's family, to make application for such employer coverage, but only if—

(I) the caretaker relative is not required to make financial contributions for such coverage (whether through payroll deduction, payment of deductibles, coinsurance, or similiar costs, or otherwise), and

(II) the State provides, directly or otherwise, for payment of any of the premium amount, deductible, coinsurance, or similar expense that the employee is otherwise required to pay; and

(ii) the State shall treat the coverage under such an employer plan as a third party liability (under section 1902(a)(25)).

Payments for premiums, deductibles, coinsurance, and similar expenses under this subparagraph shall be considered, for purposes of section 1903(a), to be payments for medical assistance.

(b) Additional 6-Month Extension.—

(1) Requirement.—Notwithstanding any other provision of this title, each State plan approved under this title shall provide that the State shall offer to each family, which has received assistance during the entire 6-month period under subsection (a) and which meets the requirement of paragraph (2)(B)(i), in the last month of the period the option of extending coverage under this subsection for the succeeding 6-month period, subject to paragraph (3).

(2) Notice and reporting requirements.—

(A) Notices.—

(i) Notice during initial extension period of option and requirements.—Each State, during the 3rd and 6th month of any extended assistance furnished to a family under subsection (a), shall notify the family of the family's option for additional extended assistance under this subsection. Each such notice shall include (I) in the 3rd month notice, a statement of the reporting requirement under subparagraph (B)(i), and, in the 6th month notice, a statement of the reporting requirement under subparagraph (B)(ii), (II) a statement as to whether any premiums are required for such additional extended assistance, and (III) a description of other out-of-pocket expenses, benefits, reporting and payment procedures, and any pre-existing condition limitations, waiting periods, or other coverage limitations imposed under any alternative coverage options offered under paragraph (4)(D). The 6th month notice under this subparagraph shall describe the amount of any premium required of a particular family for each of the first 3 months of additional extended assistance under this subsection.

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[540] P.L. 101-239, §6411(i)(3), struck out "or (v) of section 1905(a)" and substituted "of section 1905(a) or clause (i)(IV), (i)(VI), or (ii)(IX) of section 1902(a)(10)(A)", effective as if included in the enactment of P.L. 100-485.

(ii) Notice during additional extension period of reporting requirements and premiums.—Each State, during the 3rd month of any additional extended assistance furnished to a family under this subsection, shall notify the family of the reporting requirement under subparagraph (B)(ii) and a statement of the amount of any premium required for such extended assistance for the succeeding 3 months.

(B) Reporting requirements.—

(i) During initial extension period.—Each State shall require (as a condition for additional extended assistance under this subsection) that a family receiving extended assistance under subsection (a) report to the State, not later than the 21st day of the 4th month in the period of extended assistance under subsection (a), on the family's gross monthly earnings and on the family's costs for such child care as is necessary for the employment of the caretaker relative in each of the first 3 months of that period. A State may permit such additional extended assistance under this subsection notwithstanding a failure to report under this clause if the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis.[541]

(ii) During additional extension period.—Each State shall require that a family receiving extended assistance under this subsection report to the State, not later than the 21st day of the 1st month and of the 4th month in the period of additional extended assistance under this subsection, on the family's gross monthly earnings and on the family's costs for such child care as is necessary for the employment of the caretaker relative in each of the 3 preceding months.

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[541] P.L. 101-508, §4716(a)(1), added this sentence to §1925(f)(sic)(b)(2)(B)(i), effective as if included in the enactment of P.L. 100-485. Executed as if §4716(a) read "Section 1925" instead of "Subsection (f) of section 1925".

(iii) CLARIFICATION ON FREQUENCY OF REPORTING.—A State may not require that a family receiving extended assistance under this subsection or subsection (a) report more frequently than as required under clause (i) or (ii).[542]

(3) TERMINATION OF EXTENSION.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), extension of assistance during the 6-month period described in paragraph (1) to a family shall terminate (during the period) as follows:

(i) NO DEPENDENT CHILD.—The extension shall terminate at the close of the first month in which the family ceases to include a child, whether or not the child[543] is (or would if needy be) a dependent child under part A of title IV.

(ii) FAILURE TO PAY ANY PREMIUM.—If the family fails to pay any premium for a month under paragraph (5) by the 21st day of the following month, the extension shall terminate at the close of that following month, unless the family has established, to the satisfaction of the State, good cause for the failure to pay such premium on a timely basis.

(iii) QUARTERLY INCOME REPORTING AND TEST.—The extension under this subsection shall terminate at the close of the 1st or 4th month of the 6-month period if—

(I) the family fails to report to the State, by the 21st day of such month, the information required under paragraph (2)(B)(ii), unless the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis;

(II) the caretaker relative had no earnings in one or more of the previous 3 months, unless such lack of any earnings was due to an involuntary loss of employment, illness, or other good cause, established to the satisfaction of the State; or

(III) the State determines that the family's average gross monthly earnings (less such costs for such child care as is necessary for the employment of the caretaker relative) during the immediately preceding 3-month period exceed 185 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

Information described in clause (iii)(I) shall be subject to the restrictions on use and disclosure of information provided under section 402(a)(9). Instead of terminating a family's extension under clause (iii)(I), a State, at its option, may provide for suspension of the extension until the month after the month in which the family reports information required under paragraph (2)(B)(ii), but only if the family's extension has not otherwise been terminated under subclause (II) or (III) of clause (iii). The State shall make determinations under clause (iii)(III) for a family each time a report under paragraph (2)(B)(ii) for the family is received.

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[542] P.L. 101-508, §4716(a)(2), added clause (iii), effective as if included in the enactment of P.L. 100-485. Executed as if §4716(a) read "Section 1925" instead of "Subsection (f) of section 1925".

[543] P.L. 101-239, §6411(i)(1), struck out "who" and substituted ", whether or not the child", effective as if included in the enactment of P.L. 100-485.

(B) Notice before termination.—No termination of assistance shall become effective under subparagraph (A) until the State has provided the family with notice of the grounds for the termination, which notice shall include (in the case of termination under subparagraph (A)(iii)(II), relating to no continued earnings) a description of how the family may reestablish eligibility for medical assistance under the State plan. No such termination shall be effective earlier than 10 days after the date of mailing of such notice.[544]

(C) Continuation in certain cases until redetermination.—

(i) Dependent children.—With respect to a child who would cease to receive medical assistance because of subparagraph (A)(i) but who may be eligible for assistance under the State plan because the child is described in clause (i) of section 1905(a) or clause (i)(IV) (i)(VI) (i)(VII),[545], or (ii)(IX) of section 1902(a)(10)(A)[546], the State may not discontinue such assistance under such subparagraph until the State has determined that the child is not eligible for assistance under the plan.

(ii) Medically needy.—With respect to an individual who would cease to receive medical assistance because of clause (ii) or (iii) of subparagraph (A) but who may be eligible for assistance under the State plan because the individual is within a category of person for which medical assistance under the State plan is available under section 1902(a)(10)(C) (relating to medically needy individuals), the State may not discontinue such assistance under such subparagraph until the State has determined that the individual is not eligible for assistance under the plan.

(4) Coverage.—

(A) In general.—During the extension period under this subsection—

(i) the State plan shall offer to each family medical assistance which (subject to subparagraphs (B) and (C)) is the same amount, duration, and scope as would be made available to the family if it were still receiving aid under the plan approved under part A of title IV; and

(ii) the State plan may offer alternative coverage described in subparagraph (D).

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[544] P.L. 101-508, §4716(a)(3), added this sentence, effective as if included in the enactment of P.L. 100-485. Executed as if §4716(a) read "Section 1925" instead of "Subsection (f) of section 1925".

[545] P.L. 101-508, §4601(a)(3)(B), inserted "(i)(VII)," after "(VI)"*, applicable (except as otherwise provided in Vol. II, P.L. 101-508, §4601(b)(2)) to payments under title XIX for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date. *As in original; "(VI)" should probably read "(VI),".

[546] P.L. 101-239, §6411(i)(3), struck out "or (v) of section 1905(a)" and substituted "of section 1905(a) or clause (i)(IV), (i)(VI), or (ii)(IX) of section 1902(a)(10)(A)", effective as if included in the enactment of P.L. 100-485.

(B) ELIMINATION OF MOST NON-ACUTE CARE BENEFITS.—At a State's option and notwithstanding any other provision of this title, a State may choose not to provide medical assistance under this subsection with respect to any (or all) of the items and services described in paragraphs (4)(A), (6), (7), (8), (11), (13), (14), (15), (16), (18), (20), and (21) of section 1905(a).

(C) STATE MEDICAID "WRAP-AROUND" OPTION.—At a State's option, the State may elect to apply the option described in subsection (a)(4)(B) (relating to "wrap-around" coverage) for families electing medical assistance under this subsection in the same manner as such option applies to families provided extended eligibility for medical assistance under subsection (a).

(D) ALTERNATIVE ASSISTANCE.—At a State's option, the State may offer families a choice of health care coverage under one or more of the following, instead of the medical assistance otherwise made available under this subsection:

(i) ENROLLMENT IN FAMILY OPTION OF EMPLOYER PLAN.—Enrollment of the caretaker relative and dependent children in a family option of the group health plan offered to the caretaker relative.

(ii) ENROLLMENT IN FAMILY OPTION OF STATE EMPLOYEE PLAN.—Enrollment of the caretaker relative and dependent children in a family option within the options of the group health plan or plans offered by the State to State employees.

(iii) ENROLLMENT IN STATE UNINSURED PLAN.—Enrollment of the caretaker relative and dependent children in a basic State health plan offered by the State to individuals in the State (or areas of the State) otherwise unable to obtain health insurance coverage.

(iv) ENROLLMENT IN HMO.—Enrollment of the caretaker relative and dependent children in a health maintenance organization (as defined in section 1903(m)(1)(A)) less than 50 percent of the membership (enrolled on a prepaid basis) of which consists of individuals who are eligible to receive benefits under this title (other than because of the option offered under this clause). The option of enrollment under this clause is in addition to, and not in lieu of, any enrollment option that the State might offer under subparagraph (A)(i) with respect to receiving services through a health maintenance organization in accordance with section 1903(m).

If a State elects to offer an option to enroll a family under this subparagraph, the State shall pay any premiums and other costs for such enrollment imposed on the family and may pay deductibles and coinsurance imposed on the family. A State's payment of premiums for the enrollment of families under this subparagraph (not including any premiums otherwise payable by an employer and less the amount of premiums collected from such families under paragraph (5)) and payment of any deductibles and coinsurance shall be considered, for purposes of section 1903(a)(1), to be payments for medical assistance.

(E) PROHIBITION ON COST-SHARING FOR MATERNITY AND PREVENTIVE PEDIATRIC CARE.—

(i) IN GENERAL.—If a State offers any alternative option under subparagraph (D) for families, under each such option the State must assure that care described in clause (ii) is available without charge to the families through—

(I) payment of any deductibles, coinsurance, and other cost-sharing respecting such care, or

(II) providing coverage under the State plan for such care without any cost-sharing,

or any combination of such mechanisms.

(ii) CARE DESCRIBED.—The care described in this clause consists of—

(I) services related to pregnancy (including prenatal, delivery, and post partum services), and

(II) ambulatory preventive pediatric care (including ambulatory early and periodic screening, diagnosis, and treatment services under section 1905(a)(4)(B)) for each child who meets the age and date of birth requirements to be a qualified child under section 1905(n)(2).

(5) PREMIUM.—

(A) PERMITTED.—Notwithstanding any other provision of this title (including section 1916), a State may impose a premium for a family for additional extended coverage under this subsection for a premium payment period (as defined in subparagraph (D)(i)), but only if the family's average gross monthly earnings (less the average monthly costs for such child care as is necessary for the employment of the caretaker relative) for the premium base period exceed 100 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(B) LEVEL MAY VARY BY OPTION OFFERED.—The level of such premium may vary, for the same family, for each option offered by a State under paragraph (4)(D).

(C) LIMIT ON PREMIUM.—In no case may the amount of any premium under this paragraph for a family for a month in either of the premium payment periods described in subparagraph (D)(i) exceed 3 percent of the family's average gross monthly earnings (less the average monthly costs for such child care as is necessary for the employment of the caretaker relative) during the premium base period (as defined in subparagraph (D)(ii)).

(D) DEFINITIONS.—In this paragraph:

(i) A "premium payment period" described in this clause is a 3-month period beginning with the 1st or 4th month of the 6-month additional extension period provided under this subsection.

(ii) The term "premium base period" means, with respect to a particular premium payment period, the period of 3 consecutive months the last of which is 4 months before the beginning of that premium payment period.

(c) APPLICABILITY IN STATES AND TERRITORIES.—

(1) STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115(a), the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

(2) INAPPLICABILITY IN COMMONWEALTHS AND TERRITORIES.—The provisions of this section shall only apply to the 50 States and the District of Columbia.

(d) GENERAL DISQUALIFICATION FOR FRAUD.—

(1) INELIGIBILITY FOR AID.—This section shall not apply to an individual who is a member of a family which has received aid under part A of title IV if the State makes a finding that, at any time during the last 6 months in which the family was receiving such aid before otherwise being provided extended eligibility under this section, the individual was ineligible for such aid because of fraud.

(2) GENERAL DISQUALIFICATIONS.—For additional provisions relating to fraud and program abuse, see sections 1128, 1128A, and 1128B.

(e) CARETAKER RELATIVE DEFINED.—In this section, the term "caretaker relative" has the meaning of such term as used in part A of title IV.

(f) SUNSET.—This section shall not apply with respect to families that cease to be eligible for aid under part A of title IV after September 30, 1998.

ASSURING ADEQUATE PAYMENT LEVELS FOR OBSTETRICAL AND PEDIATRIC SERVICES[547]

SEC. 1926. [42 U.S.C. 1396r-7] (a)(1) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(30)(A) with respect to obstetrical services (as defined in paragraph (4)(A)), as of July 1 of each year (beginning with 1990), unless, by not later than April 1 of such year, the State submits to the Secretary an amendment to the plan that specifies the payment rates to be used for such services under the plan in the succeeding period and includes in such submission such additional data as will assist the Secretary in evaluating the State's compliance with such requirement, including data relating to how rates established for payments to health maintenance organizations under section 1903(m) take into account such payment rates.

(2) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(30)(A) with respect to pediatric services (as defined in paragraph (4)(B)), as of July 1 of each year (beginning with 1990), unless, by not later than April 1 of such year, the State submits to the Secretary an amendment to the plan that specifies, by pediatric procedure, the payment rates to be used for

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[547] P.L. 101-239, §6402(b), added this §1926, effective December 19, 1989.

such services under the plan in the succeeding period and includes in such submission such additional data as will assist the Secretary in evaluating the State's compliance with such requirement, including data relating to how rates established for payments to health maintenance organizations under section 1903(m) take into account such payment rates.

(3) The Secretary, by not later than 90 days after the date of submission of a plan amendment under paragraph (1) or (2), shall—

(A) review each such amendment for compliance with the requirement of section 1902(a)(30)(A), and

(B) approve or disapprove each such amendment.

If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

(4) In this section:

(A) The term "obstetrical services" means services relating to pregnancy covered under the State plan provided by an obstetrician, obstetrician-gynecologist, family practitioner, certified nurse midwife, or certified family nurse practitioner and does not include inpatient or outpatient hospital services or other institutional services.

(B) The term "pediatric services" means services covered under the State plan provided by a pediatrician, family practitioner, or certified pediatric nurse practitioner to children under 18 years of age and does not include inpatient or outpatient hospital services or other institutional services.

(b) For amendments submitted under subsection (a)(1) in 1992 and thereafter, the data submitted under such subsection must include, for the second previous year, at least the statewide average payment rates under the State plan for obstetrical services furnished by obstetricians, obstetrician-gynecologists, family practitioners, certified family nurse practitioners, and certified nurse midwives, by procedure. Such information shall be provided separately for providers located in each metropolitan statistical area (or similar area) in the State and in the remainder of the State.

(c) For amendments submitted under subsection (a)(2) in 1992 and thereafter, the data submitted under such subsection must include, for the second previous year, at least the statewide average payment rates under the State plan for pediatric services furnished by pediatricians, family practitioners, and certified pediatric nurse practitioners by procedure. Such information shall be provided separately for providers located in each metropolitan statistical area (or similar area) in the State and in the remainder of the State[548]

(d) Nothing in this title (including section 1902(a)(30)(A)) shall be construed as preventing a State from establishing payment levels for obstetrical or pediatric services that are higher for those services furnished in rural areas than those furnished in metropolitan statistical areas.

PAYMENT FOR COVERED OUTPATIENT DRUGS[549]

SEC. 1927. [42 U.S.C. 1396r-8] (a) REQUIREMENT FOR REBATE AGREEMENT.—

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[548] As in original; no punctuation.

[549] P.L. 101-508, §4401(a)(3), added a new §1927, effective November 5, 1990.

(1) IN GENERAL.—In order for payment to be available under section 1903(a) for covered outpatient drugs of a manufacturer, the manufacturer must have entered into and have in effect a rebate agreement described in subsection (b) with the Secretary, on behalf of States (except that, the Secretary may authorize a State to enter directly into agreements with a manufacturer). Any agreement between a State and a manufacturer prior to April 1, 1991, shall be deemed to have been entered into on January 1, 1991, and payment to such manufacturer shall be retroactively calculated as if the agreement between the manufacturer and the State had been entered into on January 1, 1991. If a manufacturer has not entered into such an agreement before March 1, 1991, such an agreement, subsequently entered into, shall not be effective until the first day of the calendar quarter that begins more than 60 days after the date the agreement is entered into.

(2) EFFECTIVE DATE.—Paragraph (1) shall first apply to drugs dispensed under this title on or after January 1, 1991.

(3) AUTHORIZING PAYMENT FOR DRUGS NOT COVERED UNDER REBATE AGREEMENTS.—Paragraph (1), and section 1903(i)(10)(A), shall not apply to the dispensing of a single source drug or innovator multiple source drug if (A)(i) the State has made a determination that the availability of the drug is essential to the health of beneficiaries under the State plan for medical assistance; (ii) such drug has been given a rating of 1-A by the Food and Drug Administration; and (iii)(I) the physician has obtained approval for use of the drug in advance of its dispensing in accordance with a prior authorization program described in subsection (d), or (II) the Secretary has reviewed and approved the State's determination under subparagraph (A); or (B) the Secretary determines that in the first calendar quarter of 1991, there were extenuating circumstances.

(4) EFFECT ON EXISTING AGREEMENTS.—In the case of a rebate agreement in effect between a State and a manufacturer on the date of the enactment of this section, such agreement, for the initial agreement period specified therein, shall be considered to be a rebate agreement in compliance with this section with respect to that State, if the State agrees to report to the Secretary any rebates paid pursuant to the agreement and such agreement provides for a minimum aggregate rebate of 10 percent of the State's total expenditures under the State plan for coverage of the manufacturer's drugs under this title. If, after the initial agreement period, the State establishes to the satisfaction of the Secretary that an agreement in effect on the date of the enactment of this section provides for rebates that are at least as large as the rebates otherwise required under this section, and the State agrees to report any rebates under the agreeement to the Secretary, the agreement shall be considered to be a rebate agreement in compliance with the section for the renewal periods of such agreement.

(b) TERMS OF REBATE AGREEMENT.—

(1) PERIODIC REBATES.—

(A) IN GENERAL.—A rebate agreement under this subsection shall require the manufacturer to provide, to each

State plan approved under this title, a rebate each calendar quarter (or periodically in accordance with a schedule specified by the Secretary) in an amount specified in subsection (c) for covered outpatient drugs of the manufacturer dispensed under the plan during the quarter (or such other period as the Secretary may specify). Such rebate shall be paid by the manufacturer not later than 30 days after the date of receipt of the information described in paragraph (2) for the period involved.

(B) OFFSET AGAINST MEDICAL ASSISTANCE.—Amounts received by a State under this section (or under an agreement authorized by the Secretary under subsection (a)(1) or an agreement described in subsection (a)(4)) in any quarter shall be considered to be a reduction in the amount expended under the State plan in the quarter for medical assistance for purposes of section 1903(a)(1).

(2) STATE PROVISION OF INFORMATION.—

(A) STATE RESPONSIBILITY.—Each State agency under this title shall report to each manufacturer not later than 60 days after the end of each calendar quarter and in a form consistent with a standard reporting format established by the Secretary, information on the total number of dosage units of each covered outpatient drug dispensed under the plan during the quarter, and shall promptly transmit a copy of such report to the Secretary.

(B) AUDITS.—A manufacturer may audit the information provided (or required to be provided) under subparagraph (A). Adjustments to rebates shall be made to the extent that information indicates that utilization was greater or less than the amount previously specified.

(3) MANUFACTURER PROVISION OF PRICE INFORMATION.—

(A) IN GENERAL.—Each manufacturer with an agreement in effect under this section shall report to the Secretary—

(i) not later than 30 days after the last day of each quarter (beginning on or after January 1, 1991), on the average manufacturer price (as defined in subsection (k)(1)) and, (for single source drugs and innovator multiple source drugs), the manufacturer's best price (as defined in subsection (c)(2)(B)) for covered outpatient drugs for the quarter, and

(ii) not later than 30 days after the date of entering into an agreement under this section on the average manufacturer price (as defined in subsection (k)(1)) as of October 1, 1990[550] for each of the manufacturer's covered outpatient drugs.

(B) VERIFICATION SURVEYS OF AVERAGE MANUFACTURER PRICE.—The Secretary may survey wholesalers and manufacturers that directly distribute their covered outpatient drugs, when necessary, to verify manufacturer prices reported under subparagraph (A). The Secretary may impose a civil monetary penalty in an amount not to exceed $100,000 on a wholesaler, manufacturer, or direct seller, if the wholesaler, manufacturer, or direct seller of a covered outpatient drug refuses a request for information about charges or prices by the Secretary in connection with a survey under this subparagraph or knowingly provides false information. The provisions of section 1128A (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

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[550] As in original. Probably should read "1990,".

(C) Penalties.—

(i) Failure to provide timely information.—In the case of a manufacturer with an agreement under this section that fails to provide information required under subparagraph (A) on a timely basis, the amount of the penalty shall be increased by $10,000 for each day in which such information has not been provided and such amount shall be paid to the Treasury, and, if such information is not reported within 90 days of the deadline imposed, the agreement shall be suspended for services furnished after the end of such 90-day period and until the date such information is reported (but in no case shall such suspension be for a period of less than 30 days).

(ii) False information.—Any manufacturer with an agreement under this section that knowingly provides false information is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such civil money penalties are in addition to other penalties as may be prescribed by law. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(D) Confidentiality of information.—Notwithstanding any other provision of law, information disclosed by manufacturers or wholesalers under this paragraph is confidential and shall not be disclosed by the Secretary or a State agency (or contractor therewith) in a form which discloses the identity of a specific manufacturer or wholesaler, prices charged for drugs by such manufacturer or wholesaler, except as the Secretary determines to be necessary to carry out this section and to permit the Comptroller General to review the information provided.

(4) Length of agreement.—

(A) In general.—A rebate agreement shall be effective for an initial period of not less than 1 year and shall be automatically renewed for a period of not less than one year unless terminated under subparagraph (B).

(B) Termination.—

(i) By the secretary.—The Secretary may provide for termination of a rebate agreement for violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 60 days after the date of notice of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, but such hearing shall not delay the effective date of the termination.

(ii) BY A MANUFACTURER.—A manufacturer may terminate a rebate agreement under this section for any reason. Any such termination shall not be effective until such period after the date of the notice as the Secretary may provide (but not beyond the term of the agreement).

(iii) EFFECTIVENESS OF TERMINATION.—Any termination under this subparagraph shall not affect rebates due under the agreement before the effective date of its termination.

(C) DELAY BEFORE REENTRY.—In the case of any rebate agreement with a manufacturer under this section which is terminated, another such agreement with the manufacturer (or a successor manufacturer) may not be entered into until a period of 1 calendar quarter has elapsed since the date of the termination, unless the Secretary finds good cause for an earlier reinstatement of such an agreement.

(c) AMOUNT OF REBATE.—

(1) BASIC REBATE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—With respect to single source drugs and innovator multiple source drugs, each manufacturer shall remit a basic rebate to the State medical assistance plan. Except as otherwise provided in this subsection, the amount of the rebate to a State for a calendar quarter (or other period specified by the Secretary) with respect to each dosage form and strength of single source drugs and innovator multiple source drugs shall be equal to the product of—

(A) the total number of units of each dosage form and strength dispensed under the plan under this title in the quarter (or other period) reported by the State under subsection (b)(2); and

(B)(i) for quarters (or periods) beginning after December 31, 1990, and before January 1, 1993, the greater of—

(I) the difference between the average manufacturer price (after deducting customary prompt payment discounts) and 87.5 percent of such price for the quarter (or other period), or

(II) the difference between the average manufacturer price for a drug and the best price (as defined in paragraph (2)(B)) for such quarter (or period) for such drug (except that for calendar quarters beginning after December 31, 1990, and ending before January 1, 1992, the rebate shall not exceed 25 percent of the average manufacturer price, and for calendar quarters beginning after December 31, 1991, and ending before January 1, 1993, the rebate shall not exceed 50 percent of the average manufacturer price); and

(ii) for quarters (or other periods) beginning after December 31, 1992, the greater of—

(I) the difference between the average manufacturer price for a drug and 85 percent of such price, or

(II) the difference between the average manufacturer price for a drug and the best price (as defined in paragraph (2)(B)) for such quarter (or period) for such drug.

(C) For the purposes of this paragraph, the term "best price" means, with respect to a single source drug or innovator multiple source drug of a manufacturer, the lowest price available from the manufacturer to any wholesaler, retailer, nonprofit entity, or governmental entity within the United States (excluding depot prices and single award contract prices, as defined by the Secretary, of any agency of the Federal Government). The best price shall be inclusive of cash discounts, free goods, volume discounts, and rebates (other than rebates under this section) and shall be determined without regard to special packaging, labeling, or identifiers on the dosage form or product or package, and shall not take into account prices that are merely nominal in amount;[551]

(D) In the case of a covered outpatient drug approved for marketing after October 1, 1990, any reference in this paragraph to "October 1, 1990" shall be a reference to the first day of the first month during which the drug was marketed.[552]

(2) Additional rebate for single source and innovator multiple source drugs.—(A) Each manufacturer shall remit an additional rebate to the State medical assistance plan in an amount equal to:

(i) For calendar quarters (or other periods) beginning after December 31, 1990 and ending before January 1, 1994—

(I) the total number of each dosage form and strength of a single source or innovator multiple source drug dispensed during the calendar quarter (or other period); multiplied by

(II)(aa) the average manufacturer price for each dosage form and strength, minus

(bb) the average manufacturer price for each such dosage form and strength in effect on October 1, 1990, increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. average) from October 1, 1990, to the month before the beginning of the calendar quarter (or other period) involved;

(ii) For calendar quarters (or other periods) beginning after December 31, 1993—

(I) the total number of each dosage form and strength of a single source or innovative multiple source drug dispensed during the calendar quarter (or other period); multiplied by

(II) the amount, if any, by which the weighted average manufacturer price for single source and innovator multiple source drugs of a manufacturer exceeds the weighted average manufacturer price for the manufacturer as of October 1, 1990, increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. average) from October 1, 1990, to the month before the beginning of the calendar quarter (or other period) involved.

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[551] As in original. Probably should read "amount.". Alignment as in original.

[552] Alignment as in original.

(B)(i) For the purposes of subparagraph (A)(ii), the term "weighted average manufacturer price" means (with respect to a calendar quarter or other period) the ratio of—

(I) the sum of the products (for all covered drugs of the manufacturer purchased under a State program under this title) of—

(aa) the average manufacturer price for each such covered drug; and

(bb) the number of units of the covered drug sold to any State program under this title during such period, to

(II) the total number of units of all such covered drugs sold under a State program under this title in such period,

except that the Secretary may exclude certain new drugs from the calculation of the weighted average if the inclusion of any such drug in such calculation has the effect of—

(aa) reducing the rebate otherwise calculated pursuant to subparagraph (A)(ii); or

(bb) increasing the rebate otherwise calculated pursuant to subparagraph (A)(ii) (in cases where such calculation under the conditions outlined in clause (ii)[553].

(ii)(I) The Secretary may exclude drugs approved by the Food and Drug Administration on or after October 1, 1990, from the calculation of weighted average manufacturer price if inclus[554] manufacturer demonstrates through a petition, in a form and manner prescribed by the Secretary, undue hardship on such manufacturer as a result of the inclusion of such drug in such calculation)[555].

(II) The Secretary may promulgate guidelines to restrict the conditions under which the Secretary may consider such petitions.

(C) For each of 8 calendar quarters beginning after December 31, 1991, the Secretary shall compare the aggregate amount of the rebates under subparagraph (A)(i) to the aggregate amount of rebates under subparagraph (A)(ii). Based on any such comparison, the Secretary may propose and utilize an alternative formula for the purpose of calculating an aggregate rebate.

(3) REBATE FOR OTHER DRUGS.—The amount of the rebate to a State for a calendar quarter (or other period specified by the Secretary) with respect to covered outpatient drugs (other than single source drugs and innovator multiple source drugs) shall be equal to the product of—

(A) the applicable percentage (as described in paragraph (4)[556] of the average manufacturer price for each dosage form and strength of such drugs (after deducting customary prompt payment discounts) for the quarter (or other period), and

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[553] As in original. Probably should read "(ii))".

[554] As in original. Probably should read "the".

[555] As in original. Probably should read "calculation.".

[556] As in original. Probably should read "(4))".

(B) the number of units of such form and dosage dispensed under the plan under this title in the quarter (or other period) reported by the State under subsection (b)(2).

(4) For the purposes of paragraph (3), the applicable percentage is—

(A) with respect to calendar quarters beginning after December 31, 1990, and ending before January 1, 1994, 10 percent; and

(B) with respect to calendar quarters beginning on or after December 31, 1993, 11 percent.

(d) Limitations on Coverage of Drugs.—

(1) Permissible restrictions.—(A) Except as provided in paragraph (6), a State may subject to prior authorization any covered outpatient drug. Any such prior authorization program shall comply with the requirements of paragraph (5).

(B) A State may exclude or otherwise restrict coverage of a covered outpatient drug if—

(i) the prescribed use is not for a medically accepted indication (as defined in (k)(6));

(ii) the drug is contained in the list referred to in paragraph (2); or

(iii) the drug is subject to such restrictions pursuant to an agreement between a manufacturer and a State authorized by the Secretary under subsection (a)(1) or in effect pursuant to subsection (a)(4).

(2) List of drugs subject to restriction.—The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted:

(A) Agents when used for anorexia or weight gain.

(B) Agents when used to promote fertility.

(C) Agents when used for cosmetic purposes or hair growth.

(D) Agents when used for the symptomatic relief of cough and colds.

(E) Agents when used to promote smoking cessation.

(F) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

(G) Nonprescription drugs.

(H) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

(I) Drugs described in section 107(c)(3) of the Drug Amendments of 1962[557] and identical, similar, or related drugs (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations ("DESI" drugs)).

(J) Barbiturates.

(K) Benzodiazepines.

(3) Update of Drug Listings.—The Secretary shall (except with respect to new drugs approved by the FDA for the first 6 months following the date of approval of such drugs shall not be subject to being listed in paragraph (2) under the provisions of

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[557] P.L. 87-781.

this paragraph), by regulation, periodically update the list of drugs described in paragraph (2) or classes of drugs, or their medical uses, which the Secretary has determined, based on data collected by surveillance and utilization review programs of State medical assistance programs, to be subject to clinical abuse or inappropriate use.

(4) INNOVATOR MULTIPLE SOURCE DRUGS.—Innovator multiple-source drugs shall be treated under applicable State and Federal law and regulation.

(5) PRIOR AUTHORIZATION PROGRAMS.—A State plan under this title may not require, as a condition of coverage or payment for a covered outpatient drug for which Federal financial participation is available in accordance with this section, the approval of the drug before its dispensing for any medically accepted indication (as defined in subsection (k)(6)) unless the system providing for such approval—

(A) provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization; and

(B) except with respect to the drugs on the list referred to in paragraph (2), provides for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation (as defined by the Secretary).

(6) TREATMENT OF NEW DRUGS.—A State may not exclude for[558] coverage, subject to prior authorization, or otherwise restrict any new biological or drug approved by the Food and Drug Administration after the date of enactment of this section, for a period of 6 months after such approval.

(7) OTHER PERMISSIBLE RESTRICTIONS.—A State may impose limitations, with respect to all such drugs in a therapeutic class, on the minimum or maximum quantities per prescription or on the number of refills, provided such limitations are necessary to discourage waste. Nothing in this section shall restrict the ability of a State to address individual instances of fraud or abuse in any manner authorized under the Social Security Act.

(8) DELAYED EFFECTIVE DATE.—The provisions of paragraph (5) shall become effective with respect to drugs dispensed under this title on or after July 1, 1991.

(e) DENIAL OF FEDERAL FINANCIAL PARTICIPATION IN CERTAIN CASES.—The Secretary shall provide that no payment shall be made to a State under section 1903(a) for an innovator multiple-source drug dispensed on or after July 1, 1991, if, under applicable State law, a less expensive noninnovator multiple source drug (other than the innovator multiple-source drug) could have been dispensed.

(f) PHARMACY REIMBURSEMENT.—

(1) NO REDUCTIONS IN REIMBURSEMENT LIMITS.—(A) During the period of time beginning on January 1, 1991, and ending on December 31, 1994, the Secretary may not modify by regulation the formula used to determine reimbursement limits described in the regulations under 42 CFR 447.331 through 42 CFR 447.334 (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1990[559]) to reduce such limits for covered outpatient drugs.

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[558] As in original.

[559] P.L. 101-508.

(B) During the period of time described in subparagraph (A), any State that was in compliance with the regulations described in subparagraph (A) may not reduce the limits for covered outpatient drugs described in subparagraph (A) or dispensing fees for such drugs.

(2) ESTABLISHMENT OF UPPER PAYMENT LIMITS.—HCFA shall establish a Federal upper reimbursement limit for each multiple source drug for which the FDA has rated three or more products therapeutically and pharmaceutically equivalent, regardless of whether all such additional formulations are rated as such and shall use only such formulations when determining any such upper limit.

(g) DRUG USE REVIEW.—

(1) IN GENERAL.—

(A) In order to meet the requirement of section 1903(i)(10)(B), a State shall provide, by not later than January 1, 1993, for a drug use review program described in paragraph (2) for covered outpatient drugs in order to assure that prescriptions (i) are appropriate, (ii) are medically necessary, and (iii) are not likely to result in adverse medical results. The program shall be designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists, and patients, or associated with specific drugs or groups of drugs, as well as potential and actual severe adverse reactions to drugs including education on therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse.

(B) The program shall assess data on drug use against predetermined standards, consistent with the following:

(i) compendia which shall consist of the following:

(I) American Hospital Formulary Service Drug Information;

(II) United States Pharmacopeia-Drug Information; and

(III) American Medical Association Drug Evaluations; and

(ii) the peer-reviewed medical literature.

(C) The Secretary, under the procedures established in section 1903, shall pay to each State an amount equal to 75 per centum of so much of the sums expended by the State plan during calendar years 1991 through 1993 as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of this subsection.

(D) States shall not be required to perform additional drug use reviews with respect to drugs dispensed to residents of nursing facilities which are in compliance with the drug regimen review procedures prescribed by the Secretary for such facilities in regulations implementing section 1919, currently at section 483.60 of title 42, Code of Federal Regulations.

(2) Description of program.—Each drug use review program shall meet the following requirements for covered outpatient drugs:

(A) Prospective drug review.—(i) The State plan shall provide for a review of drug therapy before each prescription is filled or delivered to an individual receiving benefits under this title, typically at the point-of-sale or point of distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs), incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse. Each State shall use the compendia and literature referred to in paragraph (1)(B) as its source of standards for such review.

(ii) As part of the State's prospective drug use review program under this subparagraph applicable State law shall establish standards for counseling of individuals receiving benefits under this title by pharmacists which includes at least the following:

(I) The pharmacist must offer to discuss with each individual receiving benefits under this title or caregiver of such individual (in person, whenever practicable, or through access to a telephone service which is toll-free for long-distance calls) who presents a prescription, matters which in the exercise of the pharmacist's professional judgment (consistent with State law respecting the provision of such information), the pharmacist deems significant including the following:

(aa) The name and description of the medication.

(bb) The route, dosage form, dosage, route of administration, and duration of drug therapy.

(cc) Special directions and precautions for preparation, administration and use by the patient.

(dd) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur.

(ee) Techniques for self-monitoring drug therapy.

(ff) Proper storage.

(gg) Prescription refill information.

(hh) Action to be taken in the event of a missed dose.

(II) A reasonable effort must be made by the pharmacist to obtain, record, and maintain at least the following information regarding individuals receiving benefits under this title:

(aa) Name, address, telephone number, date of birth (or age) and gender.

(bb) Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices.

(cc) Pharmacist comments relevant to the individuals[560] drug therapy.

Nothing in this clause shall be construed as requiring a pharmacist to provide consultation when an individual receiving benefits under this title or caregiver of such individual refuses such consultation.

(B) RETROSPECTIVE DRUG USE REVIEW.—The program shall provide, through its mechanized drug claims processing and information retrieval systems (approved by the Secretary under section 1903(r)) or otherwise, for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving benefits under this title, or associated with specific drugs or groups of drugs.

(C) APPLICATION OF STANDARDS.—The program shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using the compendia and literature referred to in subsection (1)(B) as the source of standards for such assessment) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care and to conserve program funds or personal expenditures.

(D) EDUCATIONAL PROGRAM.—The program shall, through its State drug use review board established under paragraph (3), either directly or through contracts with accredited health care educational institutions, State medical societies or State pharmacists associations/societies or other organizations as specified by the State, and using data provided by the State drug use review board on common drug therapy problems, provide for active and ongoing educational outreach programs (including the activities described in paragraph (3)(C)(iii) of this subsection) to educate practitioners on common drug therapy problems with the aim of improving prescribing or dispensing practices.

(3) STATE DRUG USE REVIEW BOARD.—

(A) ESTABLISHMENT.—Each State shall provide for the establishment of a drug use review board (hereinafter referred to as the "DUR Board") either directly or through a contract with a private organization.

(B) MEMBERSHIP.—The membership of the DUR Board shall include health care professionals who have recognized knowledge and expertise in one or more of the following:

(i) The clinically appropriate prescribing of covered outpatient drugs.

(ii) The clinically appropriate dispensing and monitoring of covered outpatient drugs.

(iii) Drug use review, evaluation, and intervention.

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[560] As in original. Probably should be "individual's".

(iv) Medical quality assurance.

The membership of the DUR Board shall be made up at least 1/3 but no more than 51 percent licensed and actively practicing physicians and at least 1/3 *** licensed and actively practicing pharmacists.

(C) ACTIVITIES.—The activities of the DUR Board shall include but not be limited to the following:

(i) Retrospective DUR as defined in section (2)(B).

(ii) Application of standards as defined in section (2)(C).

(iii) Ongoing interventions for physicians and pharmacists, targeted toward therapy problems or individuals identified in the course of retrospective drug use reviews performed under this subsection. Intervention programs shall include, in appropriate instances, at least:

(I) information dissemination sufficient to ensure the ready availability to physicians and pharmacists in the State of information concerning its duties, powers, and basis for its standards;

(II) written, oral, or electronic reminders containing patient-specific or drug-specific (or both) information and suggested changes in prescribing or dispensing practices, communicated in a manner designed to ensure the privacy of patient-related information;

(III) use of face-to-face discussions between health care professionals who are experts in rational drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention, including discussion of optimal prescribing, dispensing, or pharmacy care practices, and follow-up face-to-face discussions; and

(IV) intensified review or monitoring of selected prescribers or dispensers.

The Board shall re-evaluate interventions after an appropriate period of time to determine if the intervention improved the quality of drug therapy, to evaluate the success of the interventions and make modifications as necessary.

(D) ANNUAL REPORT.—Each State shall require the DUR Board to prepare a report on an annual basis. The State shall submit a report on an annual basis to the Secretary which shall include a description of the activities of the Board, including the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of such program. The Secretary shall utilize such report in evaluating the effectiveness of each State's drug use review program.

(h) ELECTRONIC CLAIMS MANAGEMENT.—

(1) IN GENERAL.—In accordance with chapter 35 of title 44, United States Code (relating to coordination of Federal information policy), the Secretary shall encourage each State agency to

establish, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system, for the purpose of performing on-line, real time eligibility verifications, claims data capture, adjudication of claims, and assisting pharmacists (and other authorized persons) in applying for and receiving payment.

(2) ENCOURAGEMENT.—In order to carry out paragraph (1)—

(A) for calendar quarters during fiscal years 1991 and 1992, expenditures under the State plan attributable to development of a system described in paragraph (1) shall receive Federal financial participation under section 1903(a)(3)(A)(i) (at a matching rate of 90 percent) if the State acquires, through applicable competitive procurement process in the State, the most cost-effective telecommunications network and automatic data processing services and equipment; and

(B) the Secretary may permit, in the procurement described in subparagraph (A) in the application of part 433 of title 42, Code of Federal Regulations, and parts 95, 205, and 307 of title 45, Code of Federal Regulations, the substitution of the State's request for proposal in competitive procurement for advance planning and implementation documents otherwise required.

(i) ANNUAL REPORT.—

(1) IN GENERAL.—Not later than May 1 of each year the Secretary shall transmit to the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and the House of Representatives a report on the the[561] operation of this section in the preceding fiscal year.

(2) DETAILS.—Each report shall include information on—

(A) ingredient costs paid under this title for single source drugs, multiple source drugs, and nonprescription covered outpatient drugs;

(B) the total value of rebates received and number of manufacturers providing such rebates;

(C) how the size of such rebates compare with the size or rebates offered to other purchasers of covered outpatient drugs;

(D) the effect of inflation on the value of rebates required under this section;

(E) trends in prices paid under this title for covered outpatient drugs; and

(F) Federal and State administrative costs associated with compliance with the provisions of this title.

(j) EXEMPTION OF ORGANIZED HEALTH CARE SETTINGS.—(1) Covered outpatient drugs dispensed by *** Health Maintenance Organizations, including those organizations that contract under section 1903(m), are not subject to the requirements of this section.

(2) The State plan shall provide that a hospital (providing medical assistance under such plan) that dispenses covered outpatient drugs using drug formulary systems, and bills the plan no more than the

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[561] As in original.

hospital's purchasing costs for covered outpatient drugs (as determined under the State plan) shall not be subject to the requirements of this section.

(3) Nothing in this subsection shall be construed as providing that amounts for covered outpatient drugs paid by the institutions described in this subsection should not be taken into account for purposes of determining the best price as described in subsection (c).

(k) DEFINITIONS.—In the section—

(1) AVERAGE MANUFACTURER PRICE.—The term "average manufacturer price" means, with respect to a covered outpatient drug of a manufacturer for a calendar quarter, the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade.

(2) COVERED OUTPATIENT DRUG.—Subject to the exceptions in paragraph (3), the term "covered outpatient drug" means—

(A) of those drugs which are treated as prescribed drugs for purposes of section 1905(a)(12), a drug which may be dispensed only upon prescription (except as provided in paragraph (5)), and—

(i) which is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act[562] or which is approved under section 505(j) of such Act;

(ii)(I) which was commercially used or sold in the United States before the date of the enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a "new drug" (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for some or all conditions of use prescribed, recommended, or suggested in its labeling; and

(B) a biological product, other than a vaccine which—

(i) may only be dispensed upon prescription,

(ii) is licensed under section 351 of the Public Health Service Act, and

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[562] P.L. 75-717.

(iii) is produced at an establishment licensed under such section to produce such product; and

(C) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act.

(3) LIMITING DEFINITION.—The term "covered outpatient drug" does not include any drug, biological product, or insulin provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made under this title as part of payment for the following and not as direct reimbursement for the drug):

(A) Inpatient hospital services.

(B) Hospice services.

(C) Dental services, except that drugs for which the State plan authorizes direct reimbursement to the dispensing dentist are covered outpatient drugs.

(D) Physicians' services.

(E) Outpatient hospital services * * * *[563] emergency room visits.

(F) Nursing facility services.

(G) Other laboratory and x-ray services.

(H) Renal dialysis.

Such term also does not include any such drug or product which is used for a medical indication which is not a medically accepted indication.

(4) NONPRESCRIPTION DRUGS.—If a State plan for medical assistance under this title includes coverage of prescribed drugs as described in section 1905(a)(12) and permits coverage of drugs which may be sold without a prescription (commonly referred to as "over-the-counter" drugs), if they are prescribed by a physician (or other person authorized to prescribe under State law), such a drug shall be regarded as a covered outpatient drug.

(5) MANUFACTURER.—The term "manufacturer" means any entity which is engaged in—

(A) the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or

(B) in the packaging, repackaging, labeling, relabeling, or distribution of prescription drug products.

Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

(6) MEDICALLY ACCEPTED INDICATION.—The term "medically accepted indication" means any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act[564], which appears in peer-reviewed medical literature or which is accepted by one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, and the United States Pharmacopeia-Drug Information.

(7) MULTIPLE SOURCE DRUG; INNOVATOR MULTIPLE SOURCE DRUG; NONINNOVATOR MULTIPLE SOURCE DRUG; SINGLE SOURCE DRUG.—

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[563] As in original.

[564] P.L. 75-717.

(A) Defined.—

(i) Multiple source drug.—The term "multiple source drug" means, with respect to a calendar quarter, a covered outpatient drug (not including any drug described in paragraph (5)) for which there are 2 or more drug products which—

(I) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations"),

(II) except as provided in subparagraph (B), are pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C) and as determined by the Food and Drug Administration, and

(III) are sold or marketed in the State during the period.

(ii) Innovator multiple source drug.—The term "innovator multiple source drug" means a multiple source drug that was originally marketed under an original new drug application approved by the Food and Drug Administration.

(iii) Noninnovator multiple source drug.—The term "noninnovator multiple source drug" means a multiple source drug that is not an innovator multiple source drug.

(iv) Single source drug.—The term "single source drug" means a covered outpatient drug which is produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributers[565] operating under the new drug application.

(B) Exception.—Subparagraph (A)(i)(II) shall not apply if the Food and Drug Administration changes by regulation the requirement that, for purposes of the publication described in subparagraph (A)(i)(I), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C).

(C) Definitions.—For purposes of this paragraph—

(i) drug products are pharmaceuutically[566] equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity;

(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence; and

(iii) a drug product is considered to be sold or marketed in a State if it appears in a published national listing of average wholesale prices selected by the Secretary, provided that the listed product is generally available to the public through retail pharmacies in that State.

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[565] As in original. Probably should read "distributors".

[566] As in original. Probably should read "pharmaceutically".

(8) STATE AGENCY.—The term "State agency" means the agency designated under section 1902(a)(5) to administer or supervise the administration of the State plan for medical assistance.

REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

SEC. 1928[567]. [42 U.S.C. 1396s] (a) AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.—For provisions of law which make additional individuals eligible for medical assistance under this title, see the following:

(1) AFDC.—(A) Section 402(a)(32) of this Act (relating to individuals who are deemed recipients of aid but for whom a payment is not made).

(B) Section 402(a)(37) of this Act (relating to individuals who lose AFDC eligibility due to increased earnings).

(C) Section 406(h) of this Act (relating to individuals who lose AFDC eligibility due to increased collection of child or spousal support).

(D) Section 482(e)(6)[568] of this Act (relating to certain individuals participating in work supplementation programs).

(2) SSI.—(A) Section 1611(e) of this Act (relating to treatment of couples sharing an accommodation in a facility).

(B) Section 1619 of this Act (relating to benefits for individuals who perform substantial gainful activity despite severe medical impairment).

(C) Section 1634(b) of this Act (relating to preservation of benefit status for disabled widows and widowers who lost SSI benefits because of 1983 changes in actuarial reduction formula).

(D) Section 1634(c) of this Act (relating to individuals who lose eligibility for SSI benefits due to entitlement to child's insurance benefits under section 202(d) of this Act).

(E) Section 1634(d) of this Act (relating to individuals who lose eligibility for SSI benefits due to entitlement to early widow's or widower's insurance benefits under section 202(e) or (f) of this Act).

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[567] P.L. 100-93, §5(b), redesignated the former §1921 as §1922, applicable to payments under this title for calendar quarters beginning after September 17, 1987, without regard to whether or not final regulations to carry out this amendment have been published by such date, except that, in the case of a State plan for medical assistance under this title which the Secretary determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by P.L. 100-93, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after August 18, 1987.

P.L. 100-203, §4211(a)(1), redesignated this section as §1923. For the effective date, see Vol. II, P.L. 100-203, §4214.

P.L. 100-203, §4112(a)(1) [as amended by P.L. 100-360, §411(k)(6)(B)(i)], redesignated §1923 as §1924, effective December 22, 1987.

P.L. 100-360, §303(a)(1)(A), redesignated this section as §1925, applicable to payments under title XIX for calendar quarters beginning on or after September 30, 1989, without regard to whether or not final regulations to carry out this amendment have been promulgated by September 30, 1989.

P.L. 100-485, §303(a)(1), redesignated this section as §1926, applicable to payments under this title for calendar quarters beginning on or after April 1, 1990 (or, in the case of the Commonwealth of Kentucky, October 1, 1990) (without regard to whether regulations to implement this amendment are promulgated by such date), with respect to families that cease to be eligible for aid under part A of title IV on or after such date.

P.L. 101-239, §6402(b), redesignated §1926 as §1927.

P.L. 101-508, §4401(a)(3), redesignated former §1927 as §1928, effective November 5, 1990.

[568] P.L. 100-485, §202(c)(5), struck out "414(g)" and substituted "482(e)(6)". For the effective date, see Vol. II, P.L. 100-485, §204(a) and (b)(1).

(3) Foster care and adoption assistance.—Sections 472(h) and 473(b) of this Act (relating to medical assistance for children in foster care and for adopted children).

(4) Refugee assistance.—Section 412(e)(5) of the Immigration and Nationality Act[569] (relating to medical assistance for certain refugees).

(5) Miscellaneous.—(A) Section 230 of Public Law 93-66 (relating to deeming eligible for medical assistance certain essential persons).

(B) Section 231 of Public Law 93-66 (relating to deeming eligible for medical assistance certain persons in medical institutions).

(C) Section 232 of Public Law 93-66 (relating to deeming eligible for medical assistance certain blind and disabled medically indigent persons).

(D) Section 13(c) of Public Law 93-233 (relating to deeming eligible for medical assistance certain individuals receiving mandatory State supplementary payments).

(E) Section 503 of Public Law 94-566 (relating to deeming eligible for medical assistance certain individuals who would be eligible for supplemental security income benefits but for cost-of-living increases in social security benefits).

(F) Section 310(b)(1) of Public Law 96-272 (relating to continuing medicaid eligibility for certain recipients of Veterans' Administration pensions).

(b) Additional State Plan Requirements.—For other provisions of law that establish additional requirements for State plans to be approved under this title, see the following:

(1) Section 1618 of this Act (relating to requirement for operation of certain State supplementation programs).

(2) Section 212(a) of Public Law 93-66 (relating to requiring mandatory minimum State supplementation of SSI benefits program).

HOME AND COMMUNITY CARE FOR FUNCTIONALLY DISABLED ELDERLY INDIVIDUALS[570]

Sec. 1929. [42 U.S.C. 1396t] (a) Home and Community Care Defined.—In this title, the term "home and community care" means one or more of the following services furnished to an individual who has been determined, after an assessment under subsection (c), to be a functionally disabled elderly individual, furnished in accordance with an individual community care plan (established and periodically reviewed and revised by a qualified community care case manager under subsection (d)):

(1) Homemaker/home health aide services.

(2) Chore services.

(3) Personal care services.

(4) Nursing care services provided by, or under the supervision of, a registered nurse.

(5) Respite care.

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[569] P.L. 82-414.

[570] P.L. 101-508, §4711(b)(1), redesignated "section 1929 as section 1930". Impossible to execute.

P.L. 101-508, §4711(b)(2), added §1929, applicable to home and community care furnished on or after July 1, 1991, without regard to whether or not final regulations to carry out this amendment have been promulgated by such date.

(6) Training for family members in managing the individual.

(7) Adult day care.

(8) In the case of an individual with chronic mental illness, day treatment or other partial hospitalization, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).

(9) Such other home and community-based services (other than room and board) as the Secretary may approve.

(b) FUNCTIONALLY DISABLED ELDERLY INDIVIDUAL DEFINED.—

(1) IN GENERAL.—In this title, the term "functionally disabled elderly individual" means an individual who—

(A) is 65 years of age or older,

(B) is determined to be a functionally disabled individual under subsection (c), and

(C) subject to section 1902(f) (as applied consistent with section 1902(r)(2)), is receiving supplemental security income benefits under title XVI (or under a State plan approved under title XVI) or, at the option of the State, is described in section 1902(a)(10)(C).

(2) TREATMENT OF CERTAIN INDIVIDUALS PREVIOUSLY COVERED UNDER A WAIVER.—(A) In the case of a State which—

(i) at the time of its election to provide coverage for home and community care under this section has a waiver approved under section 1915(c) or 1915(d) with respect to individuals 65 years of age or older, and

(ii) subsequently discontinues such waiver, individuals who were eligible for benefits under the waiver as of the date of its discontinuance and who would, but for income or resources, be eligible for medical assistance for home and community care under the plan shall, notwithstanding any other provision of this title, be deemed a functionally disabled elderly individual for so long as the individual would have remained eligible for medical assistance under such waiver.

(B) In the case of a State which used a health insuring organization before January 1, 1986, and which, as of December 31, 1990, had in effect a waiver under section 1115 that provides under the State plan under this title for personal care services for functionally disabled individuals, the term "functionally disabled elderly individual" may include, at the option of the State, an individual who—

(i) is 65 years of age or older or is disabled (as determined under the supplemental security income program under title XVI);

(ii) is determined to meet the test of functional disability applied under the waiver as of such date; and

(iii) meets the resource requirement and income standard that apply in the State to individuals described in section 1902(a)(10)(A)(ii)(V).

(3) USE OF PROJECTED INCOME.—In applying section 1903(f)(1) in determining the eligibility of an individual (described in section 1902(a)(10)(C)) for medical assistance for home and community care, a State may, at its option, provide for the determination of the individual's anticipated medical expenses (to be deducted from income) over a period of up to 6 months.

(c) DETERMINATIONS OF FUNCTIONAL DISABILITY.—

(1) IN GENERAL.—In this section, an individual is "functionally disabled" if the individual—

(A) is unable to perform without substantial assistance from another individual at least 2 of the following 3 activities of daily living: toileting, transferring, and eating; or

(B) has a primary or secondary diagnosis of Alzheimer's disease and is (i) unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision at least 2 of the following 5 activities of daily living: bathing, dressing, toileting, transferring, and eating; or (ii) cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors that pose serious health or safety hazards to himself or herself or others.

(2) ASSESSMENTS OF FUNCTIONAL DISABILITY.—

(A) REQUESTS FOR ASSESSMENTS.—If a State has elected to provide home and community care under this section, upon the request of an individual who is 65 years of age or older and who meets the requirements of subsection (b)(1)(C) (or another person on such individual's behalf), the State shall provide for a comprehensive functional assessment under this subparagraph which—

(i) is used to determine whether or not the individual is functionally disabled,

(ii) is based on a uniform minimum data set specified by the Secretary under subparagraph (C)(i), and

(iii) uses an instrument which has been specified by the State under subparagraph (B).

No fee may be charged for such an assessment.

(B) SPECIFICATION OF ASSESSMENT INSTRUMENT.—The State shall specify the instrument to be used in the State in complying with the requirement of subparagraph (A)(iii) which instrument shall be—

(i) one of the instruments designated under subparagraph (C)(ii); or

(ii) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary in subparagraph (C)(i).

(C) SPECIFICATION OF ASSESSMENT DATA SET AND INSTRUMENTS.—The Secretary shall—

(i) not later than July 1, 1991—

(I) specify a minimum data set of core elements and common definitions for use in conducting the assessments required under subparagraph (A); and

(II) establish guidelines for use of the data set; and

(ii) by not later than July 1, 1991, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subparagraph (B) for use in complying with the requirements of subparagraph (A).

(D) PERIODIC REVIEW.—Each individual who qualifies as a functionally disabled elderly individual shall have the individual's assessment periodically reviewed and revised not less often than once every 12 months.

(E) CONDUCT OF ASSESSMENT BY INTERDISCIPLINARY TEAMS.—An assessment under subparagraph (A) and a review under subparagraph (D) must be conducted by an interdisciplinary team designated by the State. The Secretary shall permit a State to provide for assessments and reviews through teams under contracts—

(i) with public organizations; or

(ii) with nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides, community care or nursing facility services.[571]

(F) CONTENTS OF ASSESSMENT.—The interdisciplinary team must—

(i) identify in each such assessment or review each individual's functional disabilities and need for home and community care, including information about the individual's health status, home and community environment, and informal support system; and

(ii) based on such assessment or review, determine whether the individual is (or continues to be) functionally disabled.

The results of such an assessment or review shall be used in establishing, reviewing, and revising the individual's ICCP under subsection (d)(1).

(G) APPEAL PROCEDURES.—Each State which elects to provide home and community care under this section must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (F).

(d) INDIVIDUAL COMMUNITY CARE PLAN (ICCP).—

(1) INDIVIDUAL COMMUNITY CARE PLAN DEFINED.—In this section, the terms "individual community care plan" and "ICCP" mean, with respect to a functionally disabled elderly individual, a written plan which—

(A) is established, and is periodically reviewed and revised, by a qualified case manager after a face-to-face interview with the individual or primary caregiver and based upon the most recent comprehensive functional assessment of such individual conducted under subsection (c)(2);

(B) specifies, within any amount, duration, and scope limitations imposed on home and community care provided under the State plan, the home and community care to be provided to such individual under the plan, and indicates the individual's preferences for the types and providers of services; and

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[571] Margin as in original.

(C) may specify other services required by such individual.

An ICCP may also designate the specific providers (qualified to provide home and community care under the State plan) which will provide the home and community care described in subparagraph (B). Nothing in this section shall be construed as authorizing an ICCP or the State to restrict the specific persons or individuals (who are competent to provide home and community care under the State plan) who will provide the home and community care described in subparagraph (B).

(2) QUALIFIED COMMUNITY CARE CASE MANAGER DEFINED.—In this section, the term "qualified community care case manager" means a nonprofit or public agency or organization which—

(A) has experience or has been trained in establishing, and in periodically reviewing and revising, individual community care plans and in the provision of case management services to the elderly;

(B) is responsible for (i) assuring that home and community care covered under the State plan and specified in the ICCP is being provided, (ii) visiting each individual's home or community setting where care is being provided not less often than once every 90 days, and (iii) informing the elderly individual or primary caregiver on how to contact the case manager if service providers fail to properly provide services or other similar problems occur;

(C) in the case of a nonpublic agency, does not provide home and community care or nursing facility services and does not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides, home and community care or nursing facility services;

(D) has procedures for assuring the quality of case management services that includes a peer review process;

(E) completes the ICCP in a timely manner and reviews and discusses new and revised ICCPs with elderly individuals or primary caregivers; and

(F) meets such other standards, established by the Secretary, as to assure that—

(i) such a manager is competent to perform case management functions;

(ii) individuals whose home and community care they manage are not at risk of financial exploitation due to such a manager; and

(iii) meets such other standards as the State may establish.

The Secretary may waive the requirement of subparagraph (C) in the case of a nonprofit agency located in a rural area.

(3) APPEALS PROCESS.—Each State which elects to provide home and community care under this section must have in effect an appeals process for individuals who disagree with the ICCP established.

(e) CEILING ON PAYMENT AMOUNTS AND MAINTENANCE OF EFFORT.—

(1) CEILING ON PAYMENT AMOUNTS.—Payments may not be made under section 1903(a) to a State for home and community care provided under this section in a quarter to the extent that

the medical assistance for such care in the quarter exceeds 50 percent of the product of—

(A) the average number of individuals in the quarter receiving such care under this section;

(B) the average per diem rate of payment which the Secretary has determined (before the beginning of the quarter) will be payable under title XVIII (without regard to coinsurance) for extended care services to be provided in the State during such quarter; and

(C) the number of days in such quarter.

(2) MAINTENANCE OF EFFORT.—

(A) ANNUAL REPORTS.—As a condition for the receipt of payment under section 1903(a) with respect to medical assistance provided by a State for home and community care (other than a waiver under section 1915(c) and other than home health care services described in section 1905(a)(7) and personal care services specified under regulations under section 1905(a)(23)), the State shall report to the Secretary, with respect to each Federal fiscal year (beginning with fiscal year 1990) and in a format developed or approved by the Secretary, the amount of funds obligated by the State with respect to the provision of home and community care to the functionally disabled elderly in that fiscal year.

(B) REDUCTION IN PAYMENT IF FAILURE TO MAINTAIN EFFORT.—If the amount reported under subparagraph (A) by a State with respect to a fiscal year is less than the amount reported under subparagraph (A) with respect to fiscal year 1989, the Secretary shall provide for a reduction in payments to the State under section 1903(a) in an amount equal to the difference between the amounts so reported.

(f) MINIMUM REQUIREMENTS FOR HOME AND COMMUNITY CARE.—

(1) REQUIREMENTS.—Home and Community care provided under this section must meet such requirements for individuals' rights and quality as are published or developed by the Secretary under subsection (k). Such requirements shall include—

(A) the requirement that individuals providing care are competent to provide such care; and

(B) the rights specified in paragraph (2).

(2) SPECIFIED RIGHTS.—The rights specified in this paragraph are as follows:

(A) The right to be fully informed in advance, orally and in writing, of the care to be provided, to be fully informed in advance of any changes in care to be provided, and (except with respect to an individual determined incompetent) to participate in planning care or changes in care.

(B) The right to voice grievances with respect to services that are (or fail to be) furnished without discrimination or reprisal for voicing grievances, and to be told how to complain to State and local authorities.

(C) The right to confidentiality of personal and clinical records.

(D) The right to privacy and to have one's property treated with respect.

(E) The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

(F) The right to education or training for oneself and for members of one's family or household on the management of care.

(G) The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in an individual's ICCP.

(H) The right to be fully informed orally and in writing of the individual's rights.

(I) Guidelines for such minimum compensation for individuals providing such care as will assure the availability and continuity of competent individuals to provide such care for functionally disabled individuals who have functional disabilities of varying levels of severity.

(J) Any other rights established by the Secretary.

(g) MINIMUM REQUIREMENTS FOR SMALL COMMUNITY CARE SETTINGS.—

(1) SMALL COMMUNITY CARE SETTINGS DEFINED.—In this section, the term "small community care setting" means—

(A) a nonresidential setting that serves more than 2 and less than 8 individuals; or

(B) a residential setting in which more than 2 and less than 8 unrelated adults reside and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

(2) MINIMUM REQUIREMENTS.—A small community care setting in which community care is provided under this section must—

(A) meet such requirements as are published or developed by the Secretary under subsection (k);

(B) meet the requirements of paragraphs (1)(A), (1)(C), (1)(D), (3), and (6) of section 1919(c), to the extent applicable to such a setting;

(C) inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting;

(D) meet any applicable State or local requirements regarding certification or licensure;

(E) meet any applicable State and local zoning, building, and housing codes, and State and local fire and safety regulations; and

(F) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents.

(h) MINIMUM REQUIREMENTS FOR LARGE COMMUNITY CARE SETTINGS.—

(1) LARGE COMMUNITY CARE SETTING DEFINED.—In this section, the term "large community care setting" means—

(A) a nonresidential setting in which more than 8 individuals are served; or

(B) a residential setting in which more than 8 unrelated adults reside and in which personal services are provided in conjunction with residing in the setting in which home and community care under this section is provided.

(2) MINIMUM REQUIREMENTS.—A large community care setting in which community care is provided under this section must—

(A) meet such requirements as are published or developed by the Secretary under subsection (k);

(B) meet the requirements of paragraphs (1)(A), (1)(C), (1)(D), (3), and (6) of section 1919(c), to the extent applicable to such a setting;

(C) inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives home and community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting; and

(D) meet the requirements of paragraphs (2) and (3) of section 1919(d) (relating to administration and other matters) in the same manner as such requirements apply to nursing facilities under such section; except that, in applying the requirement of section 1919(d)(2) (relating to life safety code), the Secretary shall provide for the application of such life safety requirements (if any) that are appropriate to the setting.

(3) DISCLOSURE OF OWNERSHIP AND CONTROL INTERESTS AND EXCLUSION OF REPEATED VIOLATORS.—A community care setting—

(A) must disclose persons with an ownership or control interest (including such persons as defined in section 1124(a)(3)) in the setting; and

(B) may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under this title or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard or to have failed to meet the requirements of paragraph (2).

(i) SURVEY AND CERTIFICATION PROCESS.—

(1) CERTIFICATIONS.—

(A) RESPONSIBILITIES OF THE STATE.—Under each State plan under this title, the State shall be responsible for certifying the compliance of providers of home and community care and community care settings with the applicable requirements of subsections (f), (g) and (h). The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(B) RESPONSIBILITIES OF THE SECRETARY.—The Secretary shall be responsible for certifying the compliance of State providers of home and community care, and of State community care settings in which such care is provided, with the requirements of subsections (f), (g) and (h).

(C) FREQUENCY OF CERTIFICATIONS.—Certification of providers and settings under this subsection shall occur no less frequently than once every 12 months.

(2) REVIEWS OF PROVIDERS.—

(A) IN GENERAL.—The certification under this subsection with respect to a provider of home or community care must be based on a periodic review of the provider's performance in providing the care required under ICCP's in accordance with the requirements of subsection (f).

(B) SPECIAL REVIEWS OF COMPLIANCE.—Where the Secretary has reason to question the compliance of a provider of home or community care with any of the requirements of subsection (f), the Secretary may conduct a review of the provider and, on the basis of that review, make independent and binding determinations concerning the extent to which the provider meets such requirements.

(3) SURVEYS OF COMMUNITY CARE SETTINGS.—

(A) IN GENERAL.—The certification under this subsection with respect to community care settings must be based on a survey. Such survey for such a setting must be conducted without prior notice to the setting. Any individual who notifies (or causes to be notified) a community care setting of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The Secretary shall review each State's procedures for scheduling and conducting such surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(B) SURVEY PROTOCOL.—Surveys under this paragraph shall be conducted based upon a protocol which the Secretary has provided for under subsection (k).

(C) PROHIBITION OF CONFLICT OF INTEREST IN SURVEY TEAM MEMBERSHIP.—A State and the Secretary may not use as a member of a survey team under this paragraph an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the community care setting being surveyed (or the person responsible for such setting) respecting compliance with the requirements of subsection (g) or (h) or who has a personal or familial financial interest in the setting being surveyed.

(D) VALIDATION SURVEYS OF COMMUNITY CARE SETTINGS.—The Secretary shall conduct onsite surveys of a representative sample of community care settings in each State, within 2 months of the date of surveys conducted under subparagraph (A) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under subparagraph (A). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under subparagraph (B). If the State has determined that an individual setting meets the requirements of subsection (g), but the Secretary determines that the setting does not meet such requirements, the Secretary's determination as to the setting's noncompliance with such requirements is binding and supersedes that of the State survey.

(E) SPECIAL SURVEYS OF COMPLIANCE.—Where the Secretary has reason to question the compliance of a community care setting with any of the requirements of subsection (g) or (h), the Secretary may conduct a survey of the setting and, on the basis of that survey, make independent and binding determinations concerning the extent to which the setting meets such requirements.

(4) INVESTIGATION OF COMPLAINTS AND MONITORING OF PROVIDERS AND SETTINGS.—Each State and the Secretary shall maintain procedures and adequate staff to investigate complaints of violations of applicable requirements imposed on providers of community care or on community care settings under subsections (f), (g) and (h).

(5) INVESTIGATION OF ALLEGATIONS OF INDIVIDUAL NEGLECT AND ABUSE AND MISAPPROPRIATION OF INDIVIDUAL PROPERTY.—The State shall provide, through the agency responsible for surveys and certification of providers of home or community care and community care settings under this subsection, for a process for the receipt, review, and investigation of allegations of individual neglect and abuse (including injuries of unknown source) by individuals providing such care or in such setting and of misappropriation of individual property by such individuals. The State shall, after notice to the individual involved and a reasonable opportunity for hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that an individual has neglected or abused an individual receiving community care or misappropriated such individual's property, the State shall notify the individual against whom the finding is made. A State shall not make a finding that a person has neglected an individual receiving community care if the person demonstrates that such neglect was caused by factors beyond the control of the person. The State shall provide for public disclosure of findings under this paragraph upon request and for inclusion, in any such disclosure of such findings, of any brief statement (or of a clear and accurate summary thereof) of the individual disputing such findings.

(6) DISCLOSURE OF RESULTS OF INSPECTIONS AND ACTIVITIES.—

(A) PUBLIC INFORMATION.—Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys, reviews, and certifications made under this subsection respecting providers of home or community care and community care settings, including statements of deficiencies,

(ii) copies of cost reports (if any) of such providers and settings filed under this title,

(iii) copies of statements of ownership under section 1124, and

(iv) information disclosed under section 1126.

(B) NOTICES OF SUBSTANDARD CARE.—If a State finds that—

(i) a provider of home or community care has provided care of substandard quality with respect to an individual, the State shall make a reasonable effort to notify promptly (I) an immediate family member of each such individual and (II) individuals receiving home or community care from that provider under this title, or

(ii) a community care setting is substandard, the State shall make a reasonable effort to notify promptly (I) individuals receiving community care in that setting, and (II) immediate family members of such individuals.

(C) ACCESS TO FRAUD CONTROL UNITS.—Each State shall provide its State medicaid fraud and abuse control unit (established under section 1903(q)) with access to all information of the State agency responsible for surveys, reviews, and certifications under this subsection.

(j) ENFORCEMENT PROCESS FOR PROVIDERS OF COMMUNITY CARE.—

(1) STATE AUTHORITY.—

(A) IN GENERAL.—If a State finds, on the basis of a review under subsection (i)(2) or otherwise, that a provider of home or community care no longer meets the requirements of this section, the State may terminate the provider's participation under the State plan and may provide in addition for a civil money penalty. Nothing in this subparagraph shall be construed as restricting the remedies available to a State to remedy a provider's deficiencies. If the State finds that a provider meets such requirements but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A) for the period during which it finds that the provider was not in compliance with such requirements.

(B) CIVIL MONEY PENALTY.—

(i) IN GENERAL.—Each State shall establish by law (whether statute or regulation) at least the following remedy: A civil money penalty assessed and collected, with interest, for each day in which the provider is or was out of compliance with a requirement of this section. Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty under subsection (i)(3)(A)) may be applied to reimbursement of individuals for personal funds lost due to a failure of home or community care providers to meet the requirements of this section. The State also shall specify criteria, as to when and how this remedy is to be applied and the amounts of any penalties. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the penalties and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

(ii) DEADLINE AND GUIDANCE.—Each State which elects to provide home and community care under this section must establish the civil money penalty remedy described in clause (i) applicable to all providers of community care covered under this section. The Secretary shall provide, through regulations or otherwise by not later than July 1, 1990, guidance to States in establishing such remedy; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedy.

(2) SECRETARIAL AUTHORITY.—

(A) FOR STATE PROVIDERS.—With respect to a State provider of home or community care, the Secretary shall have the authority and duties of a State under this subsection, except that the civil money penalty remedy described in subparagraph (C) shall be substituted for the civil money remedy described in paragraph (1)(B)(i).

(B) OTHER PROVIDERS.—With respect to any other provider of home or community care in a State, if the Secretary finds that a provider no longer meets a requirement of this section, the Secretary may terminate the provider's participation under the State plan and may provide, in addition, for a civil money penalty under subparagraph (C). If the Secretary finds that a provider meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C) for the period during which the Secretary finds that the provider was not in compliance with such requirements.

(C) CIVIL MONEY PENALTY.—If the Secretary finds on the basis of a review under subsection (i)(2) or otherwise that a home or community care provider no longer meets the requirements of this section, the Secretary shall impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The Secretary shall specify criteria, as to when and how this remedy is to be applied and the amounts of any penalties. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the penalties and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

(k) SECRETARIAL RESPONSIBILITIES.—

(1) PUBLICATION OF INTERIM REQUIREMENTS.—

(A) IN GENERAL.—The Secretary shall publish, by December 1, 1991, a proposed regulation that sets forth interim requirements, consistent with subparagraph (B), for the provision of home and community care and for community care settings, including—

(i) the requirements of subsection (c)(2) (relating to comprehensive functional assessments, including the use of assessment instruments), of subsection (d)(2)(E) (relating to qualifications for qualified case managers), of subsection (f) (relating to minimum requirements for home and community care), of subsection (g) (relating to minimum requirements for small community care settings), and of subsection (h) (relating to minimum requirements for large community care settings[572], and

(ii) survey protocols (for use under subsection (i)(3)(A)) which relate to such requirements.

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[572] As in original. Probably should read "settings)".

(B) MINIMUM PROTECTIONS.—Interim requirements under subparagraph (A) and final requirements under paragraph (2) shall assure, through methods other than reliance on State licensure processes, that individuals receiving home and community care are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of health care services by unqualified personnel in community care settings.

(2) DEVELOPMENT OF FINAL REQUIREMENTS.—The Secretary shall develop, by not later than October 1, 1992—

(A) final requirements, consistent with paragraph (1)(B), respecting the provision of appropriate, quality home and community care and respecting community care settings under this section, and including at least the requirements referred to in paragraph (1)(A)(i), and

(B) survey protocols and methods for evaluating and assuring the quality of community care settings.

The Secretary may, from time to time, revise such requirements, protocols, and methods.

(3) NO DELEGATION TO STATES.—The Secretary's authority under this subsection shall not be delegated to States.

(4) NO PREVENTION OF MORE STRINGENT REQUIREMENTS BY STATES.—Nothing in this section shall be construed as preventing States from imposing requirements that are more stringent than the requirements published or developed by the Secretary under this subsection.

(l) WAIVER OF STATEWIDENESS.—States may waive the requirement of section 1902(a)(1) (related to State wideness[573]) for a program of home and community care under this section.

(m) LIMITATION ON AMOUNT OF EXPENDITURES AS MEDICAL ASSISTANCE.—

(1) LIMITATION ON AMOUNT.—The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be for fiscal year 1991, $40,000,000, for fiscal year 1992, $70,000,000, for fiscal year 1993, $130,000,000, for fiscal year 1994, $160,000,000, and for fiscal year 1995, $180,000,000.

(2) ASSURANCE OF ENTITLEMENT TO SERVICE.—A State which receives Federal medical assistance for expenditures for home and community care under this section must provide home and community care specified under the Individual Community Care Plan under subsection (d) to individuals described in subsection (b) for the duration of the election period, without regard to the amount of funds available to the State under paragraph (1). For purposes of this paragraph, an election period is the period of 4 or more calendar quarters elected by the State, and approved by the Secretary, for the provision of home and community care under this section.

(3) LIMITATION ON ELIGIBILITY.—The State may limit eligibility for home and community care under this section during an election period under paragraph (2) to reasonable classifications (based on age, degree of functional disability, and need for services).

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[573] As in original. Probably should be "Statewideness".

(4) Allocation of medical assistance.—The Secretary shall establish a limitation on the amount of Federal medical assistance available to any State during the State's election period under paragraph (2). The limitation under this paragraph shall take into account the limitation under paragraph (1) and the number of elderly individuals age 65 or over residing in such State in relation to the number of such elderly individuals in the United States during 1990. For purposes of the previous sentence, elderly individuals shall, to the maximum extent practicable, be low-income elderly individuals.

COMMUNITY SUPPORTED LIVING ARRANGEMENTS SERVICES [574]

Sec. 1930. [42 U.S.C. 1396u] (a) Community Supported Living Arrangements Services.—In this title, the term "community supported living arrangements services" means one or more of the following services meeting the requirements of subsection (h) provided in a State eligible to provide services under this section (as defined in subsection (d)) to assist a developmentally disabled individual (as defined in subsection (b)) in activities of daily living necessary to permit such individual to live in the individual's own home, apartment, family home, or rental unit furnished in a community supported living arrangement setting:

(1) Personal assistance.

(2) Training and habilitation services (necessary to assist the individual in achieving increased integration, independence and productivity).

(3) 24-hour emergency assistance (as defined by the Secretary).

(4) Assistive technology.

(5) Adaptive equipment.

(6) Other services (as approved by the Secretary, except those services described in subsection (g)).

(7) Support services necessary to aid an individual to participate in community activities.

(b) Developmentally disabled Individual Defined.—In this title the term, "developmentally disabled individual" means an individual who as defined by the Secretary is described within the term "mental retardation and related conditions" as defined in regulations as in effect on July 1, 1990, and who is residing with the individual's family or legal guardian in such individual's own home in which no more than 3 other recipients of services under this section are residing and without regard to whether or not such individual is at risk of institutionalization (as defined by the Secretary).

(c) Criteria for Selection of Participating States.—The Secretary shall develop criteria to review the applications of States submitted under this section to provide community supported living arrangement services. The Secretary shall provide in such criteria that during the first 5 years of the provision of services under this section that no less than 2 and no more than 8 States shall be allowed to receive Federal financial participation for providing the services described in this section.

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[574] P.L. 101-508, §4712(b)(1), redesignated "section 1930 as section 1931". Impossible to execute. For the effective date, see Vol. II, P.L. 101-508, §4712(c).

P.L. 101-508, §4712(b)(2), added §1930, applicable to community supported living arrangements services furnished on or after the later of July 1, 1991, or 30 days after the publication of regulations setting forth interim requirements under subsection (h) without regard to whether or not final regulations to carry out this amendment have been promulgated by such date. The Secretary shall provide that the applications required to be submitted by States under P.L. 101-508, §4712, shall be received and approved prior to the effective date specified in the preceding sentence.

(d) Quality Assurance.—A State selected by the Secretary to provide services under this section shall in order to continue to receive Federal financial participation for providing services under this section be required to establish and maintain a quality assurance program, that provides that—

(1) the State will certify and survey providers of services under this section (such surveys to be unannounced and average at least 1 a year);

(2) the State will adopt standards for survey and certification that include—

(A) minimum qualifications and training requirements for provider staff;

(B) financial operating standards; and

(C) a consumer grievance process;

(3) the State will provide a system that allows for monitoring boards consisting of providers, family members, consumers, and neighbors;

(4) the State will establish reporting procedures to make available information to the public;

(5) the State will provide ongoing monitoring of the health and well-being of each recipient;

(6) the State will provide the services defined in subsection (a) in accordance with an individual support plan (as defined by the Secretary in regulations); and

(7) the State plan amendment under this section shall be reviewed by the State Planning Council established under section 124 of the Developmental Disabilities Assistance and Bill of Rights Act, and the Protection and Advocacy System established under section 142 of such Act.

The Secretary shall not approve a quality assurance plan under this subsection and allow a State to continue to receive Federal financial participation under this section unless the State provides for public hearings on the plan prior to adoption and implementation of its plan under this subsection.

(e) Maintenance of Effort.—States selected by the Secretary to receive Federal financial participation to provide services under this section shall maintain current levels of spending for such services in order to be eligible to continue to receive Federal financial participation for the provision of such services under this section.

(f) Excluded Services.—No Federal financial participation shall be allowed for the provision of the following services under this section:

(1) Room and board.

(2) Cost of prevocational, vocational and supported employment.

(g) Waiver of Requirements.—The Secretary may waive such provisions of this title as necessary to carry out the provisions of this section including the following requirements of this title—

(1) comparability of amount, duration, and scope of services; and

(2) statewideness.

(h) MINIMUM PROTECTIONS.—

(1) PUBLICATION OF INTERIM AND FINAL REQUIREMENTS.—

(A) IN GENERAL.—The Secretary shall publish, by July 1, 1991, a regulation (that shall be effective on an interim basis pending the promulgation of final regulations), and by October 1, 1992, a final regulation, that sets forth interim and final requirements, respectively, consistent with subparagraph (B), to protect the health, safety, and welfare of individuals receiving community supported living arrangements services.

(B) MINIMUM PROTECTIONS.—Interim and final requirements under subparagraph (A) shall assure, through methods other than reliance on State licensure processes or the State quality assurance programs under subsection (d), that—

(i) individuals receiving community supported living arrangements services are protected from neglect, physical and sexual abuse, and financial exploitation;

(ii) a provider of community supported living arrangements services may not use individuals who have been convicted of child or client abuse, neglect, or mistreatment or of a felony involving physical harm to an individual and shall take all reasonable steps to determine whether applicants for employment by the provider have histories indicating involvement in child or client abuse, neglect, or mistreatment or a criminal record involving physical harm to an individual;

(iii) individuals or entities delivering such services are not unjustly enriched as a result of abusive financial arrangements (such as owner lease-backs); and

(iv) individuals or entities delivering such services to clients, or relatives of such individuals, are prohibited from being named beneficiaries of life insurance policies purchased by (or on behalf of) such clients.

(2) SPECIFIED REMEDIES.—If the Secretary finds that a provider has not met an applicable requirement under subsection (h), the Secretary shall impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(i) TREATMENT OF FUNDS.—Any funds expended under this section for medical assistance shall be in addition to funds expended for any existing services covered under the State plan, including any waiver services for which an individual receiving services under this program is already eligible.

(j) LIMITATION ON AMOUNTS OF EXPENDITURES AS MEDICAL ASSISTANCE.—The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be for fiscal year 1991, $5,000,000, for fiscal year 1992, $10,000,000, for fiscal year 1993, $20,000,000 for fiscal year 1994, $30,000,000, for fiscal year 1995, $35,000,000, and for fiscal years thereafter such sums as provided by Congress.

TITLE XX—BLOCK GRANTS TO STATES FOR SOCIAL SERVICES[1]

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PURPOSES OF TITLE; AUTHORIZATION OF APPROPRIATIONS

SEC. 2001. [42 U.S.C. 1397] For the purposes of consolidating Federal assistance to States for social services into a single grant, increasing State flexibility in using social service grants, and encouraging each State, as far as practicable under the conditions in that State, to furnish services directed at the goals of—

(1) achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;

(2) achieving or maintaining self-sufficiency, including reduction or prevention of dependency;

(3) preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating or reuniting families;

(4) preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and

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[1] Title XX of the Social Security Act is administered by the Office of Policy, Planning, and Legislation, Office of Human Development Services, Department of Health and Human Services.

Title XX appears in the United States Code as §§1397-1397e, subchapter XX, chapter 7, Title 42.

Regulations of the Secretary of Health and Human Services relating to Title XX are contained in part 96, subtitle A, Title 45, Code of Federal Regulations.

See Vol. II, 31 U.S.C. 7501-7507 with respect to uniform audit requirements for State and local governments receiving Federal financial assistance.

See Vol. II, P.L. 79-396, §17(p), with respect to proprietary title XX center and §17(q), with respect to demonstration projects.

See Vol. II, P.L. 88-352, §601, for prohibition against discrimination in federally assisted programs.

See Vol. II, P.L. 95-521, §102(i), with respect to reporting of benefits received under the Social Security Act.

See Vol. II, P.L. 99-425, Title VI, with respect to grants for awarding scholarships to certain eligible individuals.

See Vol. II, P.L. 100-203, §9134(b), with respect to increased funding for social services block grants.

See Vol. II, P.L. 100-383, §§105(f)(2) and 206(d)(2), with respect to exclusion from income and resources of certain payments to certain individuals.

See Vol. II, 31 U.S.C. 3803(c)(2)(C), with respect to benefits not affected by P.L. 100-383.

See Vol. II, P.L. 101-239, §10405, with respect to Agent Orange settlement payments excluded from countable income and resources under Federal means-tested programs.

[2] This table of contents does not appear in the law.

(5) securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions,

there are authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the purposes of this title.

PAYMENTS TO STATES

SEC. 2002. [42 U.S.C. 1397a] (a)(1) Each State shall be entitled to payment under this title for each fiscal year in an amount equal to its allotment for such fiscal year, to be used by such State for services directed at the goals set forth in section 2001, subject to the requirements of this title.

(2) For purposes of paragraph (1)—

(A) services which are directed at the goals set forth in section 2001 include, but are not limited to, child care services, protective services for children and adults, services for children and adults in foster care, services related to the management and maintenance of the home, day care services for adults, transportation services, family planning services, training and related services, employment services, information, referral, and counseling services, the preparation and delivery of meals, health support services and appropriate combinations of services designed to meet the special needs of children, the aged, the mentally retarded, the blind, the emotionally disturbed, the physically handicapped, and alcoholics and drug addicts; and

(B) expenditures for such services may include expenditures for—

(i) administration (including planning and evaluation);

(ii) personnel training and retraining directly related to the provision of those services (including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions); and

(iii) conferences or workshops, and training or retraining through grants to nonprofit organizations within the meaning of section 501(c)(3) of the Internal Revenue Code of 1954[3] or to individuals with social services expertise, or through financial assistance to individuals participating in such conferences, workshops, and training or retraining (and this clause shall apply with respect to all persons involved in the delivery of such services).

(b) The Secretary shall make payments in accordance with section 6503 of title 31, United States Code, to each State from its allotment for use under this title.

(c) Payments to a State from its allotment for any fiscal year must be expended by the State in such fiscal year or in the succeeding fiscal year.

(d) A State may transfer up to 10 percent of its allotment under section 2003 for any fiscal year for its use for that year under other provisions of Federal law providing block grants for support of health services, health promotion and disease prevention activities, or low-income home energy assistance (or any combination of those activities). Amounts allotted to a State under any provisions of Federal law referred to in the preceding sentence and transferred by a State for use in carrying out the purposes of this title shall be treated as if they were paid to the State under this title but shall not affect the computation of the State's allotment under this title. The State shall inform the Secretary of any such transfer of funds.

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[3] P.L. 83-591.

(e) A State may use a portion of the amounts described in subsection (a) for the purpose of purchasing technical assistance from public or private entities if the State determines that such assistance is required in developing, implementing, or administering programs funded under this title.

ALLOTMENTS[4]

SEC. 2003. [42 U.S.C. 1397b] (a) The allotment for any fiscal year to each of the jurisdictions of Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands shall be an amount which bears the same ratio to the amount specified in subsection (c) as the amount which was specified for allocation to the particular jurisdiction involved for the fiscal year 1981 under section 2002(a)(2)(C) of this Act (as in effect prior to the enactment of this section[5]) bore to $2,900,000,000. The allotment for fiscal year 1989 and each succeeding fiscal year to American Samoa shall be an amount which bears the same ratio to the amount allotted to the Northern Mariana Islands for that fiscal year as the population of American Samoa bears to the population of the Northern Mariana Islands determined on the basis of the most recent data available at the time such allotment is determined.

(b) The allotment for any fiscal year for each State other than the jurisdictions of Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands shall be an amount which bears the same ratio to—

(1) the amount specified in subsection (c), reduced by

(2) the total amount allotted to those jurisdictions for that fiscal year under subsection (a),

as the population of that State bears to the population of all the States (other than Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands) as determined by the Secretary (on the basis of the most recent data available from the Department of Commerce) and promulgated prior to the first day of the third month of the preceding fiscal year.

(c) The amount specified for purposes of subsections (a) and (b) shall be—

(1) $2,400,000,000 for the fiscal year 1982;

(2) $2,450,000,000 for the fiscal year 1983;

(3) $2,700,000,000 for the fiscal years 1984, 1985, 1986, 1987, and 1989;[6]

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[4] See Vol. II, P.L. 99-190, §127, with respect to sums to be used to maintain and improve training under §401(b)(1) of P.L. 98-473.

[5] August 13, 1981 [P.L. 97-35; 95 Stat. 357].

[6] P.L. 101-239, §8016(1), struck out "and 1987, and for each succeeding fiscal year other than the fiscal year 1988; and" and substituted "1987, and 1989;", effective December 19, 1989.

(4) $2,750,000,000 for the fiscal year 1988; and[7]

(5) $2,800,000,000 for each fiscal year after fiscal year 1989.[8]

STATE ADMINISTRATION

SEC. 2004. [42 U.S.C. 1397c] Prior to expenditure by a State of payments made to it under section 2002 for any fiscal year, the State shall report on the intended use of the payments the State is to receive under this title, including information on the types of activities to be supported and the categories or characteristics of individuals to be served. The report shall be transmitted to the Secretary and made public within the State in such manner as to facilitate comment by any person (including any Federal or other public agency) during development of the report and after its completion. The report shall be revised throughout the year as may be necessary to reflect substantial changes in the activities assisted under this title, and any revision shall be subject to the requirements of the previous sentence.

LIMITATIONS ON USE OF GRANTS

SEC. 2005. [42 U.S.C. 1397d] (a) Except as provided in subsection (b), grants made under this title may not be used by the State, or by any other person with which the State makes arrangements to carry out the purposes of this title—

(1) for the purchase or improvement of land, or the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility;

(2) for the provision of cash payments for costs of subsistence or for the provision of room and board (other than costs of subsistence during rehabilitation, room and board provided for a short term as an integral but subordinate part of a social service, or temporary emergency shelter provided as a protective service);

(3) for payment of the wages of any individual as a social service (other than payment of the wages of welfare recipients employed in the provision of child day care services);

(4) for the provision of medical care (other than family planning services, rehabilitation services, or initial detoxification of an alcoholic or drug dependent individual) unless it is an integral but subordinate part of a social service for which grants may be used under this title;

(5) for social services (except services to an alcoholic or drug dependent individual or rehabilitation services) provided in and by employees of any hospital, skilled nursing facility, intermediate care facility, or prison, to any individual living in such institution;

(6) for the provision of any educational service which the State makes generally available to its residents without cost and without regard to their income;

(7) for any child day care services unless such services meet applicable standards of State and local law;

(8) for the provision of cash payments as a service (except as otherwise provided in this section); or

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[7] P.L. 101-239, §8016(2), struck out the period and substituted "; and".

[8] P.L. 101- 239, §8016(3), added paragraph (5), effective December 19, 1989.

(9) for payment for any item or service (other than an emergency item or service) furnished—

(A) by an individual or entity during the period when such individual or entity is excluded under this title or title V, XVIII, or XIX pursuant to section 1128, 1128A, 1156, or 1842(j)(2), or

(B) at the medical direction or on the prescription of a physician during the period when the physician is excluded under this title or title V, XVIII, or XIX pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

(b) The Secretary may waive the limitation contained in subsection (a)(1) and (4) upon the State's request for such a waiver if he finds that the request describes extraordinary circumstances to justify the waiver and that permitting the waiver will contribute to the State's ability to carry out the purposes of this title.

REPORTS AND AUDITS

SEC. 2006. [42 U.S.C. 1397e] (a) Each State shall prepare reports on its activities carried out with funds made available (or transferred for use) under this title. Reports shall be prepared annually, covering the most recently completed fiscal year, and shall be in such form and contain such information (including but not limited to the information specified in subsection (c)) as the State finds necessary to provide an accurate description of such activities, to secure a complete record of the purposes for which funds were spent, and to determine the extent to which funds were spent in a manner consistent with the reports required by section 2004. The State shall make copies of the reports required by this section available for public inspection within the State and shall transmit a copy to the Secretary. Copies shall also be provided, upon request, to any interested public agency, and each such agency may provide its views on these reports to the Congress.

(b) Each State shall, not less often than every two years, audit its expenditures from amounts received (or transferred for use) under this title. Such State audits shall be conducted by an entity independent of any agency administering activities funded under this title, in accordance with generally accepted auditing principles. Within 30 days following the completion of each audit, the State shall submit a copy of that audit to the legislature of the State and to the Secretary. Each State shall repay to the United States amounts ultimately found not to have been expended in accordance with this title, or the Secretary may offset such amounts against any other amount to which the State is or may become entitled under this title.

(c) Each report prepared and transmitted by a State under subsection (a) shall set forth (with respect to the fiscal year covered by the report)—

(1) the number of indiviuals who received services paid for in whole or in part with funds made available under this title, showing separately the number of children and the number of adults who received such services, and broken down in each case to reflect the types of services and circumstances involved;

(2) the amount spent in providing each such type of service, showing separately for each type of service the amount spent per child recipient and the amount spent per adult recipient;

(3) the criteria applied in determining eligibility for services (such as income eligibility guidelines, sliding fee scales, the effect of public assistance benefits, and any requirements for enrollment in school or training programs); and

(4) the methods by which services were provided, showing separately the services provided by public agencies and those provided by private agencies, and broken down in each case to reflect the types of services and circumstances involved.

The Secretary shall establish uniform definitions of services for use by the States in preparing the information required by this subsection, and make such other provision as may be necessary or appropriate to assure that compliance with the requirements of this subsection will not be unduly burdensome on the States.

(d) For other provisions requiring States to account for Federal grants, see section 6503 of title 31, United States Code.

SELECTED PROVISIONS OF THE INTERNAL REVENUE CODE OF 1986[1]

(P.L. 83-591, Approved August 16, 1954)

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Subtitle A—Income Taxes

CHAPTER 2—TAX ON SELF-EMPLOYMENT INCOME

SEC. 1401. RATE OF TAX.

(a) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to the following percent of the amount of the self-employment income for such taxable year:

In the case of a taxable year		
Beginning after:	**And before:**	**Percent:**
December 31, 1983	January 1, 1988	11.40
December 31, 1987	January 1, 1990	12.12
December 31, 1989		12.40*

*As in original. No punctuation.

(b) HOSPITAL INSURANCE.—In addition to the tax imposed by the preceding subsection, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to the following percent of the amount of the self-employment income for such taxable year:

In the case of a taxable year		
Beginning after:	**And before:**	**Percent:**
December 31, 1983	January 1, 1985	2.60
December 31, 1984	January 1, 1986	2.70
December 31, 1985		2.90.

(c)[2] RELIEF FROM TAXES IN CASES COVERED BY CERTAIN INTERNA-

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[1] To locate in U.S. Code, look for identical section number in Title 26, Internal Revenue Code.

P.L. 99-514, §2(a), provides that the Internal Revenue Title enacted August 14, 1954, may be cited as the "Internal Revenue Code of 1986" and §2(b) provides, except when inappropriate, any reference to the Internal Revenue Code of 1954 shall include a reference to the Internal Revenue Code of 1986 and any reference to the Internal Revenue Code of 1986 shall include a reference to the provisions of the Internal Revenue Code of 1954.

[2] P.L. 101-508, §11801(a)(36); 104 Stat. 1388-521, repealed the former subsection (c).

P.L. 101-508, §11801(c)(16), redesignated subsection (d) as subsection (c).

TIONAL AGREEMENTS.—During any period in which there is in effect an agreement entered into pursuant to section 233 of the Social Security Act with any foreign country, the self-employment income of an individual shall be exempt from the taxes imposed by this section to the extent that such self-employment income is subject under such agreement to taxes or contributions for similar purposes under the social security system of such foreign country.

SEC. 1402. DEFINITIONS.

(a) NET EARNINGS FROM SELF-EMPLOYMENT.—The term "net earnings from self-employment" means the gross income derived by an individual from any trade or business carried on by such individual, less the deductions allowed by this subtitle which are attributable to such trade or business, plus his distributive share (whether or not distributed) of income or loss described in section 702(a)(8) from any trade or business carried on by a partnership of which he is a member; except that in computing such gross income and deductions and such distributive share of partnership ordinary income or loss—

(1) there shall be excluded rentals from real estate and from personal property leased with the real estate (including such rentals paid in crop shares) together with the deductions attributable thereto, unless such rentals are received in the course of a trade or business as a real estate dealer; except that the preceding provisions of this paragraph shall not apply to any income derived by the owner or tenant of land if (A) such income is derived under an arrangement, between the owner or tenant and another individual, which provides that such other individual shall produce agricultural or horticultural commodities (including livestock, bees, poultry, and fur-bearing animals and wildlife) on such land, and that there shall be material participation by the owner or tenant (as determined without regard to any activities of an agent of such owner or tenant) in the production or the management of the production of such agricultural or horticultural commodities, and (B) there is material participation by the owner or tenant (as determined without regard to any activities of an agent of such owner or tenant) with respect to any such agricultural or horticultural commodity;

(2) there shall be excluded dividends on any share of stock, and interest on any bond, debenture, note, or certificate, or other evidence of indebtedness, issued with interest coupons or in registered form by any corporation (including one issued by a government or political subdivision thereof), unless such dividends and interest are received in the course of a trade or business as a dealer in stocks or securities;

(3) there shall be excluded any gain or loss—

(A) which is considered as gain or loss from the sale or exchange of a capital asset,

(B) from the cutting of timber, or the disposal of timber, coal, or iron ore, if section 631 applies to such gain or loss, or

(C) from the sale, exchange, involuntary conversion, or other disposition of property if such property is neither—

(i) stock in trade or other property of a kind which would properly be includible in inventory if on hand at the close of the taxable year, nor

(ii) property held primarily for sale to customers in the ordinary course of the trade or business;

(4) the deduction for net operating losses provided in section 172 shall not be allowed;

(5) if—

(A) any of the income derived from a trade or business (other than a trade or business carried on by a partnership) is community income under community property laws applicable to such income, all of the gross income and deductions attributable to such trade or business shall be treated as the gross income and deductions of the husband unless the wife exercises substantially all of the management and control of such trade or business, in which case all of such gross income and deductions shall be treated as the gross income and deductions of the wife; and

(B) any portion of a partner's distributive share of the ordinary income or loss from a trade or business carried on by a partnership is community income or loss under the community property laws applicable to such share, all of such distributive share shall be included in computing the net earnings from self-employment of such partner, and no part of such share shall be taken into account in computing the net earnings from self-employment of the spouse of such partner;

(6) a resident of Puerto Rico shall compute his net earnings from self-employment in the same manner as a citizen of the United States but without regard to section 933;

(7) the deduction for personal exemptions provided in section 151 shall not be allowed;

(8) an individual who is a duly ordained, commissioned, or licensed minister of a church or a member of a religious order shall compute his net earnings from self-employment derived from the performance of service described in subsection (c)(4) without regard to section 107 (relating to rental value of parsonages), section 119 (relating to meals and lodging furnished for the convenience of the employer), and section 911 (relating to citizens or residents of the United States living abroad);

(9) the exclusion from gross income provided by section 931 shall not apply;

(10) there shall be excluded amounts received by a partner pursuant to a written plan of the partnership, which meets such requirements as are prescribed by the Secretary, and which provides for payments on account of retirement, on a periodic basis, to partners generally or to a class or classes of partners, such payments to continue at least until such partner's death, if—

(A) such partner rendered no services with respect to any trade or business carried on by such partnership (or its successors) during the taxable year of such partnership (or its successors), ending within or with his taxable year, in which such amounts were received, and

(B) no obligation exists (as of the close of the partnership's taxable year referred to in subparagraph (A)) from the other partners to such partner except with respect to retirement payments under such plan, and

(C) such partner's share, if any, of the capital of the partnership has been paid to him in full before the close of the partnership's taxable year referred to in subparagraph (A);

(11) the exclusion from gross income provided by section 911(a)(1) shall not apply;

(12) in lieu of the deduction provided by section 164(f) (relating to deduction for one-half of self-employment taxes), there shall be allowed a deduction equal to the product of—

(A) the taxpayer's net earnings from self-employment for the taxable year (determined without regard to this paragraph), and

(B) one-half of the sum of the rates imposed by subsections (a) and (b) of section 1401 for such year;

(13) there shall be excluded the distributive share of any item of income or loss of a limited partner, as such, other than guaranteed payments described in section 707(c) to that partner for services actually rendered to or on behalf of the partnership to the extent that those payments are established to be in the nature of remuneration for those services;

(14) in the case of church employee income, the special rules of subsection (j)(1) shall apply; and

(15) in the case of a member of an Indian tribe, the special rules of section 7873 (relating to income derived by Indians from exercise of fishing rights) shall apply.

If the taxable year of a partner is different from that of the partnership, the distributive share which he is required to include in computing his net earnings from self-employment shall be based on the ordinary income or loss of the partnership for any taxable year of the partnership ending within or with his taxable year. In the case of any trade or business which is carried on by an individual or by a partnership and in which, if such trade or business were carried on exclusively by employees, the major portion of the services would constitute agricultural labor as defined in section 3121(g)—

(i) in the case of an individual, if the gross income derived by him from such trade or business is not more than $2,400, the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be 66 2/3 percent of such gross income; or

(ii) in the case of an individual, if the gross income derived by him from such trade or business is more than $2,400 and the net earnings from self-employment derived by him from such trade or business (computed under this subsection without regard to this sentence) are less than $1,600, the net earnings from self-employment derived by him from such trade or business may, at his option, be deemed to be $1,600; and

(iii) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the sum of all payments to which section 707(c) applies) is not more than $2,400, his distributive share of income described in section 702(a)(8) derived from such trade or business may, at his option, be deemed to be an amount equal to 66 2/3 percent of his distributive share of such gross income (after such gross income has been so reduced); or

(iv) in the case of a member of a partnership, if his distributive share of the gross income of the partnership derived from such trade or business (after such gross income has been reduced by the sum of all payments to which section 707(c) applies) is more than $2,400 and his distributive share (whether or not distributed) of income described in section 702(a)(8) derived from such trade or business (computed under this subsection without regard to this sentence) is less than $1,600, his distributive share of income described in section 702(a)(8) derived from such trade or business may, at his option, be deemed to be $1,600.

For purposes of the preceding sentence, gross income means—

(v) in the case of any such trade or business in which the income is computed under a cash receipts and disbursements method, the gross receipts from such trade or business reduced by the cost or other basis of property which was purchased and sold in carrying on such trade or business, adjusted (after such reduction) in accordance with the provisions of paragraphs (1) through (7) and paragraph (9) of this subsection; and

(vi) in the case of any such trade or business in which the income is computed under an accrual method, the gross income from such trade or business, adjusted in accordance with the provisions of paragraphs (1) through (7) and paragraph (9) of this subsection;

and, for purposes of such sentence, if an individual (including a member of a partnership) derives gross income from more than one such trade or business, such gross income (including his distributive share of the gross income of any partnership derived from any such trade or business) shall be deemed to have been derived from one trade or business.

The preceding sentence and clauses (i) through (iv) of the second preceding sentence shall also apply in the case of any trade or business (other than a trade or business specified in such second preceding sentence) which is carried on by an individual who is self-employed on a regular basis as defined in subsection (h), or by a partnership of which an individual is a member on a regular basis as defined in subsection (h), but only if such individual's net earnings from self-employment as determined without regard to this sentence in the taxable year are less than $1,600 and less than 66 2/3 percent of the sum (in such taxable year) of such individual's gross income derived from all trades or businesses carried on by him and his distributive share of the income or loss from all trades or businesses carried on by all the partnerships of which he is a member; except that this sentence shall not apply to more than 5 taxable years in the case of any individual, and in no case in which an individual elects to determine the amount of his net earnings from self-employment for a taxable year under the provisions of the two preceding sentences with respect to a trade or business to which the second preceding sentence applies and with respect to a trade or business to which this sentence applies shall such net earnings for such year exceed $1,600.

[Repealed.[3]**]**

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[3] P.L. 101-508, §5123(a)(3), 104 Stat. 1388-284, repealed this paragraph, effective with respect to income received for services performed in taxable years beginning after December 31, 1990. Until then this paragraph read as follows:

Any income of an individual which results from or is attributable to the performance of services by such individual as a director of a corporation during any taxable year shall be deemed to have

(b) SELF-EMPLOYMENT INCOME.—The term "self-employment income" means the net earnings from self-employment derived by an individual (other than a nonresident alien individual, except as provided by an agreement under section 233 of the Social Security Act) during any taxable year; except that such term shall not include—

(1) that part of the net earnings from self-employment which is in excess of (i) an amount equal to the applicable contribution base (as determined under subsection (k))[4] which is effective for the calendar year in which such taxable year begins, minus (ii) the amount of the wages paid to such individual during such taxable years; or

(2) the net earnings from self-employment, if such net earnings for the taxable year are less than $400.

For purposes of paragraph (1), the term "wages" (A) includes such remuneration paid to an employee for services included under an agreement entered into pursuant to the provisions of section 3121(l) (relating to coverage of citizens of the United States who are employees of foreign affiliates of American employers), as would be wages under section 3121(a) if such services constituted employment under section 3121(b), (B) includes compensation which is subject to the tax imposed by section 3201 or 3211, and (C) includes, but only with respect to the tax imposed by section 1401(b), remuneration paid for medicare qualified government employment (as defined in section 3121(u)(3)) which is subject to the taxes imposed by sections 3101(b) and 3111(b). An individual who is not a citizen of the United States but who is a resident of the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa shall not, for purposes of this chapter be considered to be a nonresident alien individual. In the case of church employee income, the special rules of subsection (j)(2) shall apply for purposes of paragraph (2).

(c) TRADE OR BUSINESS.—The term "trade or business", when used with reference to self-employment income or net earnings from self-employment, shall have the same meaning as when used in section 162 (relating to trade or business expenses), except that such term shall not include—

(1) the performance of the functions of a public office, other than the functions of a public office of a State or a political subdivision thereof with respect to fees received in any period in which the functions are performed in a position compensated solely on a fee basis and in which such functions are not covered under an agreement entered into by such State and the Secretary of Health and Human Services pursuant to section 218 of the Social Security Act;

(2) the performance of service by an individual as an employee, other than—

(A) service described in section 3121(b)(14)(B) performed by an individual who has attained the age of 18,

(B) service described in section 3121(b)(16),

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been derived (and received) by such individual in that year, at the time the services were performed, regardless of when the income is actually paid to or received by such individual (unless it was actually paid and received prior to that year).]

[4] P.L. 101-508, §11331(b)(1), struck out "contribution and benefit base (as determined under section 230 of the Social Security Act)" and substituted "applicable contribution and benefit base (as determined under subsection (k))".

(C) service described in section 3121(b)(11), (12), or (15) performed in the United States (as defined in section 3121(e)(2)) by a citizen of the United States,

(D) service described in paragraph (4) of this subsection,

(E) service performed by an individual as an employee of a State or a political subdivision thereof in a position compensated solely on a fee basis with respect to fees received in any period in which such service is not covered under an agreement entered into by such State and the Secretary of Health and Human Services pursuant to section 218 of the Social Security Act,

(F) service described in section 3121(b)(20), and

(G) service described in section 3121(b)(8)(B);

(3) the performance of service by an individual as an employee or employee representative as defined in section 3231;

(4) the performance of service by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order;

(5) the performance of service by an individual in the exercise of his profession as a Christian Science practitioner; or

(6) the performance of service by an individual during the period for which an exemption under subsection (g) is effective with respect to him.

The provisions of paragraph (4) or (5) shall not apply to service (other than service performed by a member of a religious order who has taken a vow of poverty as a member of such order) performed by an individual unless an exemption under subsection (e) is effective with respect to him.

(d) EMPLOYEE AND WAGES.—The term "employee" and the term "wages" shall have the same meaning as when used in chapter 21 (sec. 3101 and following, relating to Federal Insurance Contributions Act).

(e) MINISTERS, MEMBERS OF RELIGIOUS ORDERS, AND CHRISTIAN SCIENCE PRACTITIONERS.—

(1) EXEMPTION.—Subject to paragraph (2), any individual who is (A) a duly ordained, commissioned, or licensed minister of a church or a member of a religious order (other than a member of a religious order who has taken a vow of poverty as a member of such order) or (B) a Christian Science practitioner, upon filing an application (in such form and manner, and with such official, as may be prescribed by regulations made under this chapter) together with a statement that either he is conscientiously opposed to, or because of religious principles he is opposed to, the acceptance (with respect to services performed by him as such minister, member, or practitioner) of any public insurance which makes payments in the event of death, disability, old age, or retirement or makes payments toward the cost of, or provides services for, medical care (including the benefits of any insurance system established by the Social Security Act) and, in the case of an individual described in subparagraph (A), that he has informed the ordaining, commissioning, or licensing body of the church or order that he is opposed to such insurance, shall receive an exemption from the tax imposed by this chapter with

respect to services performed by him as such minister, member, or practitioner. Notwithstanding the preceding sentence, an exemption may not be granted to an individual under this subsection if he had filed an effective waiver certificate under this section as it was in effect before its amendment in 1967.

(2) VERIFICATION OF APPLICATION.—The Secretary may approve an application for an exemption filed pursuant to paragraph (1) only if the Secretary has verified that the individual applying for the exemption is aware of the grounds on which the individual may receive an exemption pursuant to this subsection and that the individual seeks exemption on such grounds. The Secretary (or the Secretary of Health and Human Services under an agreement with the Secretary) shall make such verification by such means as prescribed in regulations.

(3) TIME FOR FILING APPLICATION.—Any individual who desires to file an application pursuant to paragraph (1) must file such application on or before whichever of the following dates is later: (A) the due date of the return (including any extension thereof) for the second taxable year for which he has net earnings from self-employment (computed without regard to subsections (c)(4) and (c)(5)) of $400 or more, any part of which was derived from the performance of service described in subsection (c)(4) or (c)(5); or (B) the due date of the return (including any extension thereof) for his second taxable year ending after 1967.

(4) EFFECTIVE DATE OF EXEMPTION.—An exemption received by an individual pursuant to this subsection shall be effective for the first taxable year for which he has net earnings from self-employment (computed without regard to subsections (c)(4) and (c)(5)) of $400 or more, any part of which was derived from the performance of service described in subsection (c)(4) or (c)(5), and for all succeeding taxable years. An exemption received pursuant to this subsection shall be irrevocable.

(f) PARTNER'S TAXABLE YEAR ENDING AS THE RESULT OF DEATH.—In computing a partner's net earnings from self-employment for his taxable year which ends as a result of his death (but only if such taxable year ends within, and not with, the taxable year of the partnership), there shall be included so much of the deceased partner's distributive share of the partnership's ordinary income or loss for the partnership taxable year as is not attributable to an interest in the partnership during any period beginning on or after the first day of the first calendar month following the month in which such partner died. For purposes of this subsection—

(1) in determining the portion of the distributive share which is attributable to any period specified in the preceding sentence, the ordinary income or loss of the partnership shall be treated as having been realized or sustained ratably over the partnership taxable year; and

(2) the term "deceased partner's distributive share" includes the share of his estate or of any other person succeeding, by reason of his death, to rights with respect to his partnership interest.

(g) MEMBERS OF CERTAIN RELIGIOUS FAITHS.—

(1) EXEMPTION.—Any individual may file an application (in such form and manner, and with such official, as may be

prescribed by regulations under this chapter) for an exemption from the tax imposed by this chapter if he is a member of a recognized religious sect or division thereof and is an adherent of established tenets or teachings of such sect or division by reason of which he is conscientiously opposed to acceptance of the benefits of any private or public insurance which makes payments in the event of death, disability, old-age, or retirement or makes payments toward the cost of, or provides services for, medical care (including the benefits of any insurance system established by the Social Security Act). Such exemption may be granted only if the application contains or is accompanied by—

(A) such evidence of such individual's membership in, and adherence to the tenets or teachings of, the sect or division thereof as the Secretary may require for purposes of determining such individual's compliance with the preceding sentence, and

(B) his waiver of all benefits and other payments under titles II and XVIII of the Social Security Act on the basis of his wages and self-employment income as well as all such benefits and other payments to him on the basis of the wages and self-employment income of any other person,

and only if the Secretary of Health and Human Services finds that—

(C) such sect or division thereof has the established tenets or teachings referred to in the preceding sentence,

(D) it is the practice, and has been for a period of time which he deems to be substantial, for members of such sect or division thereof to make provision for their dependent members which in his judgment is reasonable in view of their general level of living, and

(E) such sect or division thereof has been in existence at all times since December 31, 1950.

An exemption may not be granted to any individual if any benefit or other payment referred to in subparagraph (B) became payable (or, but for section 203 or 222(b) of the Social Security Act, would have become payable) at or before the time of the filing of such waiver.

(2) PERIOD FOR WHICH EXEMPTION EFFECTIVE.—An exemption granted to any individual pursuant to this subsection shall apply with respect to all taxable years beginning after December 31, 1950, except that such exemption shall not apply for any taxable year—

(A) beginning (i) before the taxable year in which such individual first met the requirements of the first sentence of paragraph (1), or (ii) before the time as of which the Secretary of Health and Human Services finds that the sect or division thereof of which such individual is a member met the requirements of subparagraphs (C) and (D), or

(B) ending (i) after the time such individual ceases to meet the requirements of the first sentence of paragraph (1), or (ii) after the time as of which the Secretary of Health and Human Services finds that the sect or division thereof of which he is a member ceases to meet the requirements of subparagraph (C) or (D).

(3) SUBSECTION [5] TO APPLY TO CERTAIN CHURCH EMPLOYEES.—This subsection shall [6] apply with respect to services which are described in subparagraph (B) of section 3121(b)(8) (and are not described in subparagraph (A) of such section).

(h) REGULAR BASIS.—An individual shall be deemed to be self-employed on a regular basis in a taxable year, or to be a member of a partnership on a regular basis in such year, if he had net earnings from self-employment, as defined in the first sentence of subsection (a), of not less than $400 in at least two of the three consecutive taxable years immediately preceding such taxable year from trades or businesses carried on by such individual or such partnership.

(i) SPECIAL RULES FOR OPTIONS AND COMMODITIES DEALERS.—

(1) IN GENERAL.—Notwithstanding subsection (a)(3)(A), in determining the net earnings from self-employment of any options dealer or commodities dealer, there shall not be excluded any gain or loss (in the normal course of the taxpayer's activity of dealing in or trading section 1256 contracts) from section 1256 contracts or property related to such contracts.

(2) DEFINITIONS.—For purposes of this subsection—

(A) OPTIONS DEALER.—The term "options dealer" has the meaning given such term by section 1256(g)(8).

(B) COMMODITIES DEALER.—The term "commodities dealer" means a person who is actively engaged in trading section 1256 contracts and is registered with a domestic board of trade which is designated as a contract market by the Commodities Futures Trading Commission.

(C) SECTION 1256 CONTRACTS.—The term "section 1256 contract" has the meaning given to such term by section 1256(b).

(j) SPECIAL RULES FOR CERTAIN CHURCH EMPLOYEE INCOME.—

(1) COMPUTATION OF NET EARNINGS.—In applying subsection (a)—

(A) church employee income shall not be reduced by any deduction;

(B) church employee income and deductions attributable to such income shall not be taken into account in determining the amount of other net earnings from self-employment.

(2) COMPUTATION OF SELF-EMPLOYMENT INCOME.—

(A) SEPARATE APPLICATION OF SUBSECTION (b)(2).—Paragraph (2) of subsection (b) shall be applied separately—

(i) to church employee income, and

(ii) to other net earnings from self-employment.

(B) $100 FLOOR.—In applying paragraph (2) of subsection (b) to church employee income, "$100" shall be substituted for "$400".

(3) COORDINATION WITH SUBSECTION (a)(12).—Paragraph (1) shall not apply to any amount allowable as a deduction under subsection (a)(12), and paragraph (1) shall be applied before determining the amount so allowable.

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[5] P.L. 101-239, §10204(a)(1)(A), struck out "NOT".

[6] P.L. 101-239, §10204(a)(1)(B), struck out "not".

(4) Church employee income defined.—For purposes of this section, the term "church employee income" means gross income for services which are described in section 3121(b)(8)(B) (and are not described in section 3121(b)(8)(A)).

(k) Applicable Contribution Base.—For purposes of this chapter—

(1) Old-Age, survivors, and disability insurance.—For purposes of the tax imposed by section 1401(a), the applicable contribution base for any calendar year is the contribution and benefit base determined under section 230 of the Social Security Act for such calendar year.

(2) Hospital insurance.—For purposes of the tax imposed by section 1401(b), the applicable contribution base for any calendar year is the applicable contribution base determined under section 3121(x)(2) for such calendar year.[7]

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Subtitle C—Employment Taxes

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CHAPTER 21—FEDERAL INSURANCE CONTRIBUTIONS ACT

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SUBCHAPTER A—TAX ON EMPLOYEES

SEC. 3101. RATE OF TAX.

(a) Old-Age, Survivors, and Disability Insurance.—In addition to other taxes, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b))—

In cases of wages received during:	**The rate shall be:**
1984, 1985, 1986, or 1987	5.7 percent
1988 or 1989	6.06 percent
1990 or thereafter	6.2 percent.

(b) Hospital Insurance.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b))—

(1) with respect to wages received during the calendar years 1974 through 1977, the rate shall be 0.90 percent;

(2) with respect to wages received during the calendar year 1978, the rate shall be 1.00 percent;

(3) with respect to wages received during the calendar years 1979 and 1980, the rate shall be 1.05 percent;

(4) with respect to wages received during the calendar years 1981 through 1984, the rate shall be 1.30 percent;

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[7] P.L. 101-508, §11331(b)(2), added subsection (k).

(5) with respect to wages received during the calendar year 1985, the rate shall be 1.35 percent; and

(6) with respect to wages received after December 31, 1985, the rate shall be 1.45 percent.

(c) RELIEF FROM TAXES IN CASES COVERED BY CERTAIN INTERNATIONAL AGREEMENTS.—During any period in which there is in effect an agreement entered into pursuant to section 233 of the Social Security Act with any foreign country, wages received by or paid to an individual shall be exempt from the taxes imposed by this section to the extent that such wages are subject under such agreement to taxes or contributions for similar purposes under the social security system of such foreign country.

SEC. 3102. DEDUCTION OF TAX FROM WAGES.

(a) REQUIREMENT.—The tax imposed by section 3101 shall be collected by the employer of the taxpayer, by deducting the amount of the tax from the wages as and when paid. An employer who in any calendar quarter pays to an employee cash remuneration to which paragraph (7)(B) of section 3121(a) is applicable may deduct an amount equivalent to such tax from any such payment of remuneration, even though at the time of payment the total amount of such remuneration paid to the employee by the employer in the calendar quarter is less than $50; and an employer who in any calendar year pays to an employee cash remuneration to which paragraph (7)(C) or (10) of section 3121(a) is applicable may deduct an amount equivalent to such tax from any such payment of remuneration, even though at the time of payment the total amount of such remuneration paid to the employee by the employer in the calendar year is less than $100; and an employer who in any calendar year pays to an employee cash remuneration to which paragraph (8)(B) of section 3121(a) is applicable may deduct an amount equivalent to such tax from any such payment of remuneration, even though at the time of payment the total amount of such remuneration paid to the employee by the employer in the calendar year is less than $150 and the employee has not performed agricultural labor for the employer on 20 days or more in the calendar year for cash remuneration computed on a time basis; and an employer who is furnished by an employee a written statement of tips (received in a calendar month) pursuant to section 6053(a) to which paragraph (12)(B) of section 3121(a) is applicable may deduct an amount equivalent to such tax with respect to such tips from any wages of the employee (exclusive of tips) under his control, even though at the time such statement is furnished the total amount of the tips included in statements furnished to the employer as having been received by the employee in such calendar month in the course of his employment by such employer is less than $20.

(b) INDEMNIFICATION OF EMPLOYER.—Every employer required so to deduct the tax shall be liable for the payment of such tax, and shall be indemnified against the claims and demands of any person for the amount of any such payment made by such employer.

(c) SPECIAL RULE FOR TIPS.—

(1) In the case of tips which constitute wages, subsection (a) shall be applicable only to such tips as are included in a written statement furnished to the employer pursuant to section 6053(a), and only to the extent that collection can be made by the

employer, at or after the time such statement is so furnished and before the close of the 10th day following the calendar month (or, if paragraph (3) applies, the 30th day following the year) in which the tips were deemed paid, by deducting the amount of the tax from such wages of the employee (excluding tips, but including funds turned over by the employee to the employer pursuant to paragraph (2)) as are under control of the employer.

(2) If the tax imposed by section 3101, with respect to tips which are included in written statements furnished in any month to the employer pursuant to section 6053(a), exceeds the wages of the employee (excluding tips) from which the employer is required to collect the tax under paragraph (1), the employee may furnish to the employer on or before the 10th day of the following month (or, if paragraph (3) applies, on or before the 30th day of the following year) an amount of money equal to the amount of the excess.

(3) The Secretary may, under regulations prescribed by him, authorize employers—

(A) to estimate the amount of tips that will be reported by the employee pursuant to section 6053(a) in any calendar year,

(B) to determine the amount to be deducted upon each payment of wages (exclusive of tips) during such year as if the tips so estimated constituted the actual tips so reported, and

(C) to deduct upon any payment of wages (other than tips, but including funds turned over by the employee to the employer pursuant to paragraph (2)) to such employee during such year (and within 30 days thereafter) such amount as may be necessary to adjust the amount actually deducted upon such wages of the employee during the year to the amount required to be deducted in respect of tips included in written statements furnished to the employer during the year.

(4) If the tax imposed by section 3101 with respect to tips which constitute wages exceeds the portion of such tax which can be collected by the employer from the wages of the employee pursuant to paragraph (1) or paragraph (3), such excess shall be paid by the employee.

(d) SPECIAL RULE FOR CERTAIN TAXABLE GROUP-TERM LIFE INSURANCE BENEFITS.—

(1) IN GENERAL.—In the case of any payment for group-term life insurance to which this subsection applies—

(A) subsection (a) shall not apply,

(B) the employer shall separately include on the statement required under section 6051—

(i) the portion of the wages which consists of payments for group-term life insurance to which this subsection applies, and

(ii) the amount of the tax imposed by section 3101 on such payments, and

(C) the tax imposed by section 3101 on such payments shall be paid by the employee.

(2) BENEFITS TO WHICH SUBSECTION APPLIES.—This subsection shall apply to any payment for group-term life insurance to the extent—

(A) such payment constitutes wages, and

(B) such payment is for coverage for periods during which an employment relationship no longer exists between the employee and the employer.[8]

SUBCHAPTER B—TAX ON EMPLOYERS

SEC. 3111. RATE OF TAX.

(a) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b))—

In cases of wages paid during:	**The rate shall be:**
1984, 1985, 1986, or 1987	5.7 percent
1988 or 1989	6.06 percent
1990 or thereafter	6.2 percent.

(b) HOSPITAL INSURANCE.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b))—

(1) with respect to wages paid during the calendar years 1974 through 1977, the rate shall be 0.90 percent;

(2) with respect to wages paid during the calendar year 1978, the rate shall be 1.00 percent;

(3) with respect to wages paid during the calendar years 1979 and 1980, the rate shall be 1.05 percent;

(4) with respect to wages paid during the calendar years 1981 through 1984, the rate shall be 1.30 percent;

(5) with respect to wages paid during the calendar year 1985, the rate shall be 1.35 percent; and

(6) with respect to wages paid after December 31, 1985, the rate shall be 1.45 percent.

(c) RELIEF FROM TAXES IN CASES COVERED BY CERTAIN INTERNATIONAL AGREEMENTS.—During any period in which there is in effect an agreement entered into pursuant to section 233 of the Social Security Act with any foreign country, wages received by or paid to an individual shall be exempt from the taxes imposed by this section to the extent that such wages are subject under such agreement to taxes or contributions for similar purposes under the social security system of such foreign country.

SEC. 3112. INSTRUMENTALITIES OF THE UNITED STATES.

Notwithstanding any other provision of law (whether enacted before or after the enactment of this section) which grants to any instrumentality of the United States an exemption from taxation, such instrumentality shall not be exempt from the tax imposed by section 3111 unless such other provision of law grants a specific exemption, by reference to section 3111 (or the corresponding section of prior law), from the tax imposed by such section.

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[8] P.L. 101-508, §5124(a), added subsection (d).

SUBCHAPTER C—GENERAL PROVISIONS

SEC. 3121. DEFINITIONS.

(a) WAGES.—For purposes of this chapter, the term "wages" means all remuneration for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash; except that such term shall not include—

(1) that part of the remuneration which, after remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) equal to the applicable contribution base (as determined under subsection (x))[9] with respect to employment has been paid to an individual by an employer during the calendar year with respect to which such applicable contribution base[10] is effective, is paid to such individual by such employer during such calendar year. If an employer (hereinafter referred to as successor employer) during any calendar year acquires substantially all the property used in a trade or business of another employer (hereinafter referred to as a predecessor), or used in a separate unit of a trade or business of a predecessor, and immediately after the acquisition employs in his trade or business an individual who immediately prior to the acquisition was employed in the trade or business of such predecessor, then, for the purpose of determining whether the successor employer has paid remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment equal to the applicable contribution base (as determined under subsection (x))[11] to such individual during such calendar year, any remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment paid (or considered under this paragraph as having been paid) to such individual by such predecessor during such calendar year and prior to such acquisition shall be considered as having been paid by such successor employer;

(2) the amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of his dependents under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally and their dependents) or for a class or classes of his employees (or for a class or classes of his employees and their dependents), on account of—

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[9] P.L. 101-508, §11331(a)(1)(A), struck out "contribution and benefit base (as determined under section 230 of the Social Security Act)" and substituted "applicable contribution base (as determined under subsection (x))".

[10] P.L. 101-508, §11331(a)(1)(B), struck out "contribution and benefit base" and substituted "applicable contribution base".

[11] P.L. 101-508, §11331(a), struck out "contribution and benefit base (as determined under section 230 of the Social Security Act)" and substituted "applicable contribution base (as determined under subsection (x))".

(A) sickness or accident disability (but, in the case of payments made to an employee or any of his dependents, this subparagraph shall exclude from the term "wages" only payments which are received under a workmen's compensation law), or

(B) medical or hospitalization expenses in connection with sickness or accident disability, or

(C) death, except that this paragraph does not apply to a payment for group-term life insurance to the extent that such payment is includible in the gross income of the employee;

[(3) Stricken.[12]]

(4) any payment on account of sickness or accident disability, or medical or hospitalization expenses in connection with sickness or accident disability, made by an employer to, or on behalf of, an employee after the expiration of 6 calendar months following the last calendar month in which the employee worked for such employer;

(5) any payment made to, or on behalf of, an employee or his beneficiary—

(A) from or to a trust described in section 401(a) which is exempt from tax under section 501(a) at the time of such payment unless such payment is made to an employee of the trust as remuneration for services rendered as such employee and not as a beneficiary of the trust,

(B) under or to an annuity plan which, at the time of such payment, is a plan described in section 403(a),

(C) under a simplified employee pension (as defined in section 408(k)(1)), other than any contributions described in section 408(k)(6),

(D) under or to an annuity contract described in section 403(b), other than a payment for the purchase of such contract which is made by reason of a salary reduction agreement (whether evidenced by a written instrument or otherwise),

(E) under or to an exempt governmental deferred compensation plan (as defined in subsection (v)(3)),

(F) to supplement pension benefits under a plan or trust described in any of the foregoing provisions of this paragraph to take into account some portion or all of the increase in the cost of living (as determined by the Secretary of Labor) since retirement but only if such supplemental payments are under a plan which is treated as a welfare plan under section 3(2)(B)(ii) of the Employee Retirement Income Security Act of 1974, or

(G) under a cafeteria plan (within the meaning of section 125) if such payment would not be treated as wages without regard to such plan and it is reasonable to believe that (if section 125 applied for purposes of this section) section 125 would not treat any wages as constructively received;

(6) the payment by an employer (without deduction from the remuneration of the employee)—

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[12] P.L. 98-21, §324(a)(3)(B); 97 Stat. 123.

(A) of the tax imposed upon an employee under section 3101, or

(B) of any payment required from an employee under a State unemployment compensation law,

with respect to remuneration paid to an employee for domestic service in a private home of the employer or for agricultural labor;

(7)(A) remuneration paid in any medium other than cash to an employee for service not in the course of the employer's trade or business or for domestic service in a private home of the employer;

(B) cash remuneration paid by an employer in any calendar quarter to an employee for domestic service in a private home of the employer, if the cash remuneration paid in such quarter by the employer to the employee for such service is less than $50. As used in this subparagraph, the term "domestic service in a private home of the employer" does not include service described in subsection (g)(5);

(C) cash remuneration paid by an employer in any calendar year to an employee for service not in the course of the employer's trade or business, if the cash remuneration paid in such year by the employer to the employee for such service is less than $100. As used in this subparagraph, the term "service not in the course of the employer's trade or business" does not include domestic service in a private home of the employer and does not include service described in subsection (g)(5);

(8)(A) remuneration paid in any medium other than cash for agricultural labor;

(B) cash remuneration paid by an employer in any calendar year to an employee for agricultural labor unless—

(i) the cash remuneration paid in such year by the employer to the employee for such labor is $150 or more, or

(ii) the employer's expenditures for agricultural labor in such year equal or exceed $2,500,

except that clause (ii) shall not apply in determining whether remuneration paid to an employee constitutes "wages" under this section if such employee (I) is employed as a hand harvest laborer and is paid on a piece rate basis in an operation which has been, and is customarily and generally recognized as having been, paid on a piece rate basis in the region of employment, (II) commutes daily from his permanent residence to the farm on which he is so employed, and (III) has been employed in agriculture less than 13 weeks during the preceding calendar year;

[(9) Stricken.[13]**]**

(10) remuneration paid by an employer in any calendar year to an employee for service described in subsection (d)(3)(C) (relating to home workers), if the cash remuneration paid in such year by the employer to the employee for such service is less than $100;

(11) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of the payment of such remuneration it is reasonable to believe that a corresponding deduction is

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[13] P.L. 98-21, §324(a)(3)(B); 97 Stat. 123.

allowable under section 217 (determined without regard to section 274(n));

(12)(A) tips paid in any medium other than cash;

(B) cash tips received by an employee in any calendar month in the course of his employment by an employer unless the amount of such cash tips is $20 or more;

(13) any payment or series of payments by an employer to an employee or any of his dependents which is paid—

(A) upon or after the termination of an employee's employment relationship because of (i) death, or (ii) retirement for disability, and

(B) under a plan established by the employer which makes provision for his employees generally or a class or classes of his employees (or for such employees or class or classes of employees and their dependents),

other than any such payment or series of payments which would have been paid if the employee's employment relationship had not been so terminated;

(14) any payment made by an employer to a survivor or the estate of a former employee after the calendar year in which such employee died;

(15) any payment made by an employer to an employee, if at the time such payment is made such employee is entitled to disability insurance benefits under section 223(a) of the Social Security Act and such entitlement commenced prior to the calendar year in which such payment is made, and if such employee did not perform any services for such employer during the period for which such payment is made;

(16) remuneration paid by an organization exempt from income tax under section 501(a) (other than an organization described in section 401(a)) or under section 521 in any calendar year to an employee for service rendered in the employ of such organization, if the remuneration paid in such year by the organization to the employee for such service is less than $100;

(17) any contribution, payment, or service provided by an employer which may be excluded from the gross income of an employee, his spouse, or his dependents, under the provisions of section 120 (relating to amounts received under qualified group legal services plans);

(18) any payment made, or benefit furnished, to or for the benefit of an employee if at the time of such payment or such furnishing it is reasonable to believe that the employee will be able to exclude such payment or benefit from income under section 127 or 129;

(19) the value of any meals or lodging furnished by or on behalf of the employer if at the time of such furnishing it is reasonable to believe that the employee will be able to exclude such items from income under section 119;

(20) any benefit provided to or on behalf of an employee if at the time such benefit is provided it is reasonable to believe that the employee will be able to exclude such benefit from income under section 74(c), 117, or 132; or

(21) in the case of a member of an Indian tribe, any remuneration on which no tax is imposed by this chapter by reason of

section 7873 (relating to income derived by Indians from exercise of fishing rights).

Nothing in the regulations prescribed for purposes of chapter 24 (relating to income tax withholding) which provides an exclusion from "wages" as used in such chapter shall be construed to require a similar exclusion from "wages" in the regulations prescribed for purposes of this chapter. Except as otherwise provided in regulations prescribed by the Secretary, any third party which makes a payment included in wages solely by reason of the parenthetical matter contained in subparagraph (A) of paragraph (2) shall be treated for purposes of this chapter and chapter 22 as the employer with respect to such wages.

(b) EMPLOYMENT.—For purposes of this chapter, the term "employment" means any service, of whatever nature, performed (A) by an employee for the person employing him, irrespective of the citizenship or residence of either, (i) within the United States, or (ii) on or in connection with an American vessel or American aircraft under a contract of service which is entered into within the United States or during the performance of which and while the employee is employed on the vessel or aircraft it touches at a port in the United States, if the employee is employed on and in connection with such vessel or aircraft when outside the United States, or (B) outside the United States by a citizen or resident of the United States as an employee for an American employer (as defined in subsection (h)), or (C) if it is service, regardless of where or by whom performed, which is designated as employment or recognized as equivalent to employment under an agreement entered into under section 233 of the Social Security Act; except that such term shall not include—

(1) service performed by foreign agricultural workers lawfully admitted to the United States from the Bahamas, Jamaica, and the other British West Indies, or from any other foreign country or possession thereof, on a temporary basis to perform agricultural labor;

(2) domestic service performed in a local college club, or local chapter of a college fraternity or sorority, by a student who is enrolled and is regularly attending classes at a school, college, or university;

(3)(A) service performed by a child under the age of 18 in the employ of his father or mother;

(B) service not in the course of the employer's trade or business, or domestic service in a private home of the employer, performed by an individual under the age of 21 in the employ of his father or mother, or performed by an individual in the employ of his spouse or son or daughter; except that the provisions of this subparagraph shall not be applicable to such domestic service performed by an individual in the employ of his son or daughter if—

(i) the employer is a surviving spouse or a divorced individual and has not remarried, or has a spouse living in the home who has a mental or physical condition which results in such spouse's being incapable of caring for a son, daughter, stepson, or stepdaughter (referred to in clause (ii)) for at least 4 continuous weeks in the calendar quarter in which the service is rendered, and

(ii) a son, daughter, stepson, or stepdaughter of such employer is living in the home, and

(iii) the son, daughter, stepson, or stepdaughter (referred to in clause (ii)) has not attained age 18 or has a mental or physical condition which requires the personal care and supervision of an adult for at least 4 continuous weeks in the calendar quarter in which the service is rendered;

(4) service performed by an individual on or in connection with a vessel not an American vessel, or on or in connection with an aircraft not an American aircraft, if (A) the individual is employed on and in connection with such vessel or aircraft, when outside the United States and (B)(i) such individual is not a citizen of the United States or (ii) the employer is not an American employer;

(5) service performed in the employ of the United States or any instrumentality of the United States, if such service—

(A) would be excluded from the term "employment" for purposes of this title if the provisions of paragraphs (5) and (6) of this subsection as in effect in January 1983 had remained in effect, and

(B) is performed by an individual who—

(i) has been continuously performing service described in subparagraph (A) since December 31, 1983, and for purposes of this clause—

(I) if an individual performing service described in subparagraph (A) returns to the performance of such service after being separated therefrom for a period of less than 366 consecutive days, regardless of whether the period began before, on, or after December 31, 1983, then such service shall be considered continuous,

(II) if an individual performing service described in subparagraph (A) returns to the performance of such service after being detailed or transferred to an international organization as described under section 3343 of subchapter III of chapter 33 of title 5, United States Code, or under section 3581 of chapter 35 of such title, then the service performed for that organization shall be considered service described in subparagraph (A),

(III) if an individual performing service described in subparagraph (A) is reemployed or reinstated after being separated from such service for the purpose of accepting employment with the American Institute in Taiwan as provided under section 3310 of chapter 48 of title 22, United States Code, then the service performed for that Institute shall be considered service described in subparagraph (A),

(IV) if an individual performing service described in subparagraph (A) returns to the performance of such service after performing service as a member of a uniformed service (including, for purposes of this clause, service in the National Guard and temporary service in the Coast Guard Reserve) and after exercising restoration or reemployment rights as provided under chapter 43 of title 38, United States Code, then the service so performed as a member of a uniformed service shall be considered service described in subparagraph (A), and

(V) if an individual performing service described in subparagraph (A) returns to the performance of such service after employment (by a tribal organization) to which section 105(e)(2) of the Indian Self-Determination Act applies, then the service performed for that tribal organization shall be considered service described in subparagraph (A); or

(ii) is receiving an annuity from the Civil Service Retirement and Disability Fund, or benefits (for service as an employee) under another retirement system established by a law of the United States for employees of the Federal Government (other than for members of the uniformed service);

except that this paragraph shall not apply with respect to any such service performed on or after any date on which such individual performs—

(C) service performed as the President or Vice President of the United States,

(D) service performed—

(i) in a position placed in the Executive Schedule under sections 5312 through 5317 of title 5, United States Code,

(ii) as a noncareer appointee in the Senior Executive Service or a noncareer member of the Senior Foreign Service, or

(iii) in a position to which the individual is appointed by the President (or his designee) or the Vice President under section 105(a)(1), 106(a)(1), or 107(a)(1) or (b)(1) of title 3, United States Code, if the maximum rate of basic pay for such position is at or above the rate for level V of the Executive Schedule,

(E) service performed as the Chief Justice of the United States, an Associate Justice of the Supreme Court, a judge of a United States court of appeals, a judge of a United States district court (including the district court of a territory), a judge of the United States Claims Court, a judge of the United States Court of International Trade, a judge of the United States Tax Court, a United States magistrate, or a referee in bankruptcy or United States bankruptcy judge,

(F) service performed as a Member, Delegate, or Resident Commissioner of or to the Congress,

(G) any other service in the legislative branch of the Federal Government if such service—

(i) is performed by an individual who was not subject to subchapter III of chapter 83 of title 5, United States Code, or to another retirement system established by a law of the United States for employees of the Federal Government (other than for members of the uniformed services), on December 31, 1983, or

(ii) is performed by an individual who has, at any time after December 31, 1983, received a lump-sum payment under section 8342(a) of title 5, United States Code, or under the corresponding provision of the law establishing the other retirement system described in clause (i), or

(iii) is performed by an individual after such individual has otherwise ceased to be subject to subchapter III of chapter 83 of title 5, United States Code (without having an application pending for coverage under such subchapter), while performing service in the legislative branch (determined without regard to the provisions of subparagraph (B) relating to continuity of employment), for any period of time after December 31, 1983,

and for purposes of this subparagraph (G) an individual is subject to such subchapter III or to any such other retirement system at any time only if (a) such individual's pay is subject to deductions, contributions, or similar payments (concurrent with the service being performed at that time) under section 8334(a) of such title 5 or the corresponding provision of the law establishing such other system, or (in a case to which section 8332(k)(1) of such title applies) such individual is making payments of amounts equivalent to such deductions, contributions, or similar payments while on leave without pay, or (b) such individual is receiving an annuity from the Civil Service Retirement and Disability Fund, or is receiving benefits (for service as an employee) under another retirement system established by a law of the United States for employees of the Federal Government (other than for members of the uniformed services), or

(H) service performed by an individual—

(i) on or after the effective date of an election by such individual, under section 301 of the Federal Employees' Retirement System Act of 1986 or section 307 of the Central Intelligence Agency Retirement Act of 1964 for Certain Employees, to become subject to the Federal Employees' Retirement System provided in chapter 84 of title 5, United States Code, or

(ii) on or after the effective date of an election by such individual, under regulations issued under section 860 of the Foreign Service Act of 1980, to become subject to the Foreign Service Pension System provided in subchapter II of chapter 8 of title I of such Act;

(6) service performed in the employ of the United States or any instrumentality of the United States if such service is performed—

(A) in a penal institution of the United States by an inmate thereof;

(B) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the Federal Government), other than as a medical or dental intern or a medical or dental resident in training; or

(C) by any individual as an employee serving on a temporary basis in case of fire, storm, earthquake, flood, or other similar emergency;

(7) service performed in the employ of a State, or any political subdivision thereof, or any instrumentality of any one or more of the foregoing which is wholly owned thereby, except that this paragraph shall not apply in the case of—

(A) service which, under subsection (j), constitutes covered transportation service,

(B) service in the employ of the Government of Guam or the Government of American Samoa or any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, performed by an officer or employee thereof (including a member of the legislature of any such Government or political subdivision), and, for purposes of this title with respect to the taxes imposed by this chapter—

(i) any person whose service as such an officer or employee is not covered by a retirement system established by a law of the United States shall not, with respect to such service, be regarded as an employee of the United States or any agency or instrumentality thereof, and

(ii) the remuneration for service described in clause (i) (including fees paid to a public official) shall be deemed to have been paid by the Government of Guam or the Government of American Samoa or by a political subdivision thereof or an instrumentality of any one or more of the foregoing which is wholly owned thereby, whichever is appropriate,

(C) service performed in the employ of the District of Columbia or any instrumentality which is wholly owned thereby, if such service is not covered by a retirement system established by a law of the United States; except that the provisions of this subparagraph shall not be applicable to service performed—

(i) in a hospital or penal institution by a patient or inmate thereof;

(ii) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or as a medical or dental resident in training;

(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency; or

(iv) by a member of a board, committee, or council of the District of Columbia, paid on a per diem, meeting, or other fee basis,[14]

(D) service performed in the employ of the Government of Guam (or any instrumentality which is wholly owned by such Government) by an employee properly classified as a temporary or intermittent employee, if such service is not covered by a retirement system established by a law of Guam; except that (i) the provisions of this subparagraph shall not be applicable to services performed by an elected official or a member of the legislature or in a hospital or penal institution by a patient or inmate thereof, and (ii) for purposes of this subparagraph, clauses (i) and (ii) of subparagraph (B) shall apply,[15]

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[14] As in original; possibly should be a semicolon.

(E) service included under an agreement entered into pursuant to section 218 of the Social Security Act, or[16]

(F) service in the employ of a State (other than the District of Columbia, Guam, or American Samoa), of any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, by an individual who is not a member of a retirement system of such State, political subdivision, or instrumentality, except that the provisions of this subparagraph shall not be applicable to service performed—

(i) by an individual who is employed to relieve such individual from unemployment;

(ii) in a hospital, home, or other institution by a patient or inmate thereof,

(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency;

(iv) by an election official or election worker if the remuneration paid in a calendar year for such service is less than $100; or

(v) by an employee in a position compensated solely on a fee basis which is treated pursuant to section 1402(c)(2)(E) as a trade or business for purposes of inclusion of such fees in net earnings from self-employment;

for purposes of this subparagraph, except as provided in regulations prescribed by the Secretary, the term "retirement system" has the meaning given such term by section 218(b)(4) of the Social Security Act.[17]

(8)(A) service performed by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order, except that this subparagraph shall not apply to service performed by a member of such an order in the exercise of such duties, if an election of coverage under subsection (r) is in effect with respect to such order, or with respect to the autonomous subdivision thereof to which such member belongs;

(B) service performed in the employ of a church or qualified church-controlled organization if such church or organization has in effect an election under subsection (w), other than service in an unrelated trade or business (within the meaning of section 513(a));

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[15] P.L. 101-508, §11332(b)(1), struck out "or".

[16] P.L. 101-508, §11332(b)(2), struck out the semicolon and substituted ", or".

[17] P.L. 101-508, §11332(b)(3), added subparagraph (F).

(9) service performed by an individual as an employee or employee representative as defined in section 3231;

(10) service performed in the employ of—

(A) a school, college, or university, or

(B) an organization described in section 509(a)(3) if the organization is organized, and at all times thereafter is operated, exclusively for the benefit of, to perform the functions of, or to carry out the purposes of a school, college, or university and is operated, supervised, or controlled by or in connection with such school, college, or university, unless it is a school, college, or university of a State or a political subdivision thereof and the services performed in its employ by a student referred to in section 218(c)(5) of the Social Security Act are covered under the agreement between the Secretary of Health and Human Services and such State entered into pursuant to section 218 of such Act;

if such service is performed by a student who is enrolled and regularly attending classes at such school, college, or university;

(11) service performed in the employ of a foreign government (including service as a consular or other officer or employee or a nondiplomatic representative);

(12) service performed in the employ of an instrumentality wholly owned by a foreign government—

(A) if the service is of a character similar to that performed in foreign countries by employees of the United States Government or of an instrumentality thereof; and

(B) if the Secretary of State shall certify to the Secretary of the Treasury that the foreign government, with respect to whose instrumentality and employees thereof exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States Government and of instrumentalities thereof;

(13) service performed as a student nurse in the employ of a hospital or a nurses' training school by an individual who is enrolled and is regularly attending classes in a nurses' training school chartered or approved pursuant to State law;

(14)(A) service performed by an individual under the age of 18 in the delivery or distribution of newspapers or shopping news, not including delivery or distribution to any point for subsequent delivery or distribution;

(B) service performed by an individual in, and at the time of, the sale of newspapers or magazines to ultimate consumers, under an arrangement under which the newspapers or magazines are to be sold by him at a fixed price, his compensation being based on the retention of the excess of such price over the amount at which the newspapers or magazines are charged to him, whether or not he is guaranteed a minimum amount of compensation for such service, or is entitled to be credited with the unsold newspapers or magazines turned back;

(15) service performed in the employ of an international organization;

(16) service performed by an individual under an arrangement with the owner or tenant of land pursuant to which—

(A) such individual undertakes to produce agricultural or horticultural commodities (including livestock, bees, poultry, and fur-bearing animals and wildlife) on such land,

(B) the agricultural or horticultural commodities produced by such individual, or the proceeds therefrom, are to be divided between such individual and such owner or tenant, and

(C) the amount of such individual's share depends on the amount of the agricultural or horticultural commodities produced;

(17) service in the employ of any organization which is performed (A) in any year during any part of which such organization is registered, or there is in effect a final order of the Subversive Activities Control Board requiring such organization to register, under the Internal Security Act of 1950, as amended, as a Communist-action organization, a Communist-front organization, or a Communist-infiltrated organization, and (B) after June 30, 1956;

(18) service performed in Guam by a resident of the Republic of the Philippines while in Guam on a temporary basis as a nonimmigrant alien admitted to Guam pursuant to section 101(a)(15)(H)(ii) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(H)(ii));

(19) Service[18] which is performed by a nonresident alien individual for the period he is temporarily present in the United States as a nonimmigrant under subparagraph (F), (J), or (M) of section 101(a)(15) of the Immigration and Nationality Act, as amended, and which is performed to carry out the purpose specified in subparagraph (F), (J), or (M), as the case may be; or

(20) service (other than service described in paragraph (3)(A)) performed by an individual on a boat engaged in catching fish or other forms of aquatic animal life under an arrangement with the owner or operator of such boat pursuant to which—

(A) such individual does not receive any cash remuneration (other than as provided in subparagraph (B)),

(B) such individual receives a share of the boat's (or the boats' in the case of a fishing operation involving more than one boat) catch of fish or other forms of aquatic animal life or a share of the proceeds from the sale of such catch, and

(C) the amount of such individual's share depends on the amount of the boat's (or the boats' in the case of a fishing operation involving more than one boat) catch of fish or other forms of aquatic animal life,

but only if the operating crew of such boat (or each boat from which the individual receives a share in the case of a fishing operation involving more than one boat) is normally made up of fewer than 10 individuals.

(c) INCLUDED AND EXCLUDED SERVICE.—For purposes of this chapter, if the services performed during one-half or more of any pay period by an employee for the person employing him constitute employment, all the services of such employee for such period shall be deemed to be employment; but if the services performed during more than one-half of any such pay period by an employee for the person employing him do not constitute employment, then none of the services of such employee for such period shall be deemed to be employment. As used in this subsection, the term "pay period" means a period (of not more than 31 consecutive days) for which a payment of remuneration is ordinarily made to the employee by the person employing him. This subsection shall not be applicable with respect to services performed in a pay period by an employee for the person employing him, where any of such service is excepted by subsection (b)(9).

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[18] As in original. Possibly should be "service".

(d) EMPLOYEE.—For purposes of this chapter, the term "employee" means—

(1) any officer of a corporation; or

(2) any individual who, under the usual common law rules applicable in determining the employer-employee relationship, has the status of an employee; or

(3) any individual (other than an individual who is an employee under paragraph (1) or (2)) who performs services for remuneration for any person—

(A) as an agent-driver or commission-driver engaged in distributing meat products, vegetable products, fruit products, bakery products, beverages (other than milk), or laundry or dry-cleaning services, for his principal;

(B) as a full-time life insurance salesman;

(C) as a home worker performing work, according to specifications furnished by the person for whom the services are performed, on materials or goods furnished by such person which are required to be returned to such person or a person designated by him; or

(D) as a traveling or city salesman, other than as an agent-driver or commission-driver, engaged upon a full-time basis in the solicitation on behalf of, and the transmission to, his principal (except for side-line sales activities on behalf of some other person) of orders from wholesalers, retailers, contractors, or operators of hotels, restaurants, or other similar establishments for merchandise for resale or supplies for use in their business operations;

if the contract of service contemplates that substantially all of such services are to be performed personally by such individual; except that an individual shall not be included in the term "employee" under the provisions of this paragraph if such individual has a substantial investment in facilities used in connection with the performance of such services (other than in facilities for transportation), or if the services are in the nature of a single transaction not part of a continuing relationship with the person for whom the services are performed; or

(4) any individual who performs services that are included under an agreement entered into pursuant to section 218 of the Social Security Act.

(e) STATE, UNITED STATES, AND CITIZEN.—For purposes of this chapter—

(1) STATE.—The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(2) UNITED STATES.—The term "United States" when used in a geographical sense includes the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

An individual who is a citizen of the Commonwealth of Puerto Rico (but not otherwise a citizen of the United States) shall be considered, for purposes of this section, as a citizen of the United States.

(f) AMERICAN VESSEL AND AIRCRAFT.—For purposes of this chapter, the term "American vessel" means any vessel documented or numbered under the laws of the United States; and includes any vessel which is neither documented or numbered under the laws of the United States nor documented under the laws of any foreign country, if its crew is employed solely by one or more citizens or residents of the United States or corporations organized under the laws of the United States or of any State; and the term "American aircraft" means an aircraft registered under the laws of the United States.

(g) AGRICULTURAL LABOR.—For purposes of this chapter, the term "agricultural labor" includes all service performed—

(1) on a farm, in the employ of any person, in connection with cultivating the soil, or in connection with raising or harvesting any agricultural or horticultural commodity, including the raising, shearing, feeding, caring for, training, and management of livestock, bees, poultry, and fur-bearing animals and wildlife;

(2) in the employ of the owner or tenant or other operator of a farm, in connection with the operation, management, conservation, improvement, or maintenance of such farm and its tools and equipment, or in salvaging timber or clearing land of brush and other debris left by a hurricane, if the major part of such service is performed on a farm;

(3) in connection with the production or harvesting of any commodity defined as an agricultural commodity in section 15(g) of the Agricultural Marketing Act, as amended (12 U.S.C. 1141j), or in connection with the ginning of cotton, or in connection with the operation or maintenance of ditches, canals, reservoirs, or waterways, not owned or operated for profit, used exclusively for supplying and storing water for farming purposes;

(4)(A) in the employ of the operator of a farm in handling, planting, drying, packing, packaging, processing, freezing, grading, storing, or delivering to storage or to market or to a carrier for transportation to market, in its unmanufactured state, any agricultural or horticultural commodity; but only if such operator produced more than one-half of the commodity with respect to which such service is performed;

(B) in the employ of a group of operators of farms (other than a cooperative organization) in the performance of service described in subparagraph (A), but only if such operators produced all of the commodity with respect to which such service is performed. For purposes of this subparagraph, any unincorporated group of operators shall be deemed a cooperative organization if the number of operators comprising such group is more than 20 at any time during the calendar year in which such service is performed;

(C) the provisions of subparagraphs (A) and (B) shall not be deemed to be applicable with respect to service performed in connection with commercial canning or commercial freezing or in connection with any agricultural or horticultural commodity after its delivery to a terminal market for distribution for consumption; or

(5) on a farm operated for profit if such service is not in the course of the employer's trade or business or is domestic service in a private home of the employer.

As used in this subsection, the term "farm" includes stock, dairy, poultry, fruit, fur-bearing animal, and truck farms, plantations, ranches, nurseries, ranges, greenhouses or other similar structures used primarily for the raising of agricultural or horticultural commodities, and orchards.

(h) AMERICAN EMPLOYER.—For purposes of this chapter, the term "American employer" means an employer which is—

(1) the United States or any instrumentality thereof,

(2) an individual who is a resident of the United States,

(3) a partnership, if two-thirds or more of the partners are residents of the United States,

(4) a trust, if all of the trustees are residents of the United States, or

(5) a corporation organized under the laws of the United States or of any State.

(i) COMPUTATION OF WAGES IN CERTAIN CASES.—

(1) DOMESTIC SERVICE.—For purposes of this chapter, in the case of domestic service described in subsection (a)(7)(B), any payment of cash remuneration for such service which is more or less than a whole-dollar amount shall, under such conditions and to such extent as may be prescribed by regulations made under this chapter, be computed to the nearest dollar. For the purpose of the computation to the nearest dollar, the payment of a fractional part of a dollar shall be disregarded unless it amounts to one-half dollar or more, in which case it shall be increased to $1. The amount of any payment of cash remuneration so computed to the nearest dollar shall, in lieu of the amount actually paid, be deemed to constitute the amount of cash remuneration for purposes of subsection (a)(7)(B).

(2) SERVICE IN THE UNIFORMED SERVICES.—For purposes of this chapter, in the case of an individual performing service, as a member of a uniformed service, to which the provisions of subsection (m)(1) are applicable, the term "wages" shall, subject to the provisions of subsection (a)(1) of this section, include as such individual's remuneration for such service only (A) his basic pay as described in chapter 3 and section 1009 of title 37, United States Code, in the case of an individual performing service to which subparagraph (A) of such subsection (m)(1) applies, or (B) his compensation for such service as determined under section 206(a) of title 37, United States Code, in the case of an individual performing service to which subparagraph (B) of such subsection (m)(1) applies.

(3) PEACE CORPS VOLUNTEER SERVICE.—For purposes of this chapter, in the case of an individual performing service, as a volunteer or volunteer leader within the meaning of the Peace Corps Act, to which the provisions of section 3121(p) are applicable, the term "wages" shall, subject to the provisions of subsection (a)(1) of this section, include as such individual's remu-

neration for such service only amounts paid pursuant to section 5(c) or 6(1) of the Peace Corps Act.

(4) SERVICE PERFORMED BY CERTAIN MEMBERS OF RELIGIOUS ORDERS.—For purposes of this chapter, in any case where an individual is a member of a religious order (as defined in subsection (r)(2)) performing service in the exercise of duties required by such order, and an election of coverage under subsection (r) is in effect with respect to such order or with respect to the autonomous subdivision thereof to which such member belongs, the term "wages" shall, subject to the provisions of subsection (a)(1), include as such individual's remuneration for such service the fair market value of any board, lodging, clothing, and other perquisites furnished to such member by such order or subdivision thereof or by any other person or organization pursuant to an agreement with such order or subdivision, except that the amount included as such individual's remuneration under this paragraph shall not be less than $100 a month.

(5) SERVICE PERFORMED BY CERTAIN RETIRED JUSTICES AND JUDGES.—For purposes of this chapter, in the case of an individual performing service under the provisions of section 294 of title 28, United States Code (relating to assignment of retired justices and judges to active duty), the term "wages" shall not include any payment under section 371(b) of such title 28 which is received during the period of such service.

(j) COVERED TRANSPORTATION SERVICE.—For purposes of this chapter—

(1) EXISTING TRANSPORTATION SYSTEMS—GENERAL RULE.—Except as provided in paragraph (2), all service performed in the employ of a State or political subdivision in connection with its operation of a public transportation system shall constitute covered transportation service if any part of the transportation system was acquired from private ownership after 1936 and prior to 1951.

(2) EXISTING TRANSPORTATION SYSTEMS—CASES IN WHICH NO TRANSPORTATION EMPLOYEES, OR ONLY CERTAIN EMPLOYEES, ARE COVERED.—Service performed in the employ of a State or political subdivision in connection with the operation of its public transportation system shall not constitute covered transportation service if—

(A) any part of the transportation system was acquired from private ownership after 1936 and prior to 1951, and substantially all service in connection with the operation of the transportation system was, on December 31, 1950, covered under a general retirement system providing benefits which, by reason of a provision of the State constitution dealing specifically with retirement systems of the State or political subdivisions thereof, cannot be diminished or impaired; or

(B) no part of the transportation system operated by the State or political subdivision on December 31, 1950, was acquired from private ownership after 1936 and prior to

1951;

except that if such State or political subdivision makes an acquisition after 1950 from private ownership of any part of its transportation system, then, in the case of any employee who—

(C) became an employee of such State or political subdivision in connection with and at the time of its acquisition after 1950 of such part, and

(D) prior to such acquisition rendered service in employment (including as employment service covered by an agreement under section 218 of the Social Security Act) in connection with the operation of such part of the transportation system acquired by the State or political subdivision,

the service of such employee in connection with the operation of the transportation system shall constitute covered transportation service, commencing with the first day of the third calendar quarter following the calendar quarter in which the acquisition of such part took place, unless on such first day such service of such employee is covered by a general retirement system which does not, with respect to such employee, contain special provisions applicable only to employees described in subparagraph (C).

(3) TRANSPORTATION SYSTEMS ACQUIRED AFTER 1950.—All service performed in the employ of a State or political subdivision thereof in connection with its operation of a public transportation system shall constitute covered transportation service if the transportation system was not operated by the State or political subdivision prior to 1951 and, at the time of its first acquisition (after 1950) from private ownership of any part of its transportation system, the State or political subdivision did not have a general retirement system covering substantially all service performed in connection with the operation of the transportation system.

(4) DEFINITIONS.—For purposes of this subsection—

(A) The term "general retirement system" means any pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof for employees of the State, political subdivision, or both; but such term shall not include such a fund or system which covers only service performed in positions connected with the operation of its public transportation system.

(B) A transportation system or a part thereof shall be considered to have been acquired by a State or political subdivision from private ownership if prior to the acquisition service performed by employees in connection with the operation of the system or part thereof acquired constituted employment under this chapter or subchapter A of chapter 9 of the Internal Revenue Code of 1939 or was covered by an agreement made pursuant to section 218 of the Social Security Act and some of such employees became employees of the State or political subdivision in connection with and at the time of such acquisition.

(C) The term "political subdivision" includes an instrumentality of—

(i) a State,

(ii) one or more political subdivisions of a State, or

(iii) a State and one or more of its political subdivisions.

[(k) Repealed.[19]]

(l) AGREEMENTS ENTERED INTO BY AMERICAN EMPLOYERS WITH RESPECT TO FOREIGN AFFILIATES.—

(1) AGREEMENT WITH RESPECT TO CERTAIN EMPLOYEES OF FOREIGN AFFILIATE.—The Secretary shall, at the American employer's request, enter into an agreement (in such manner and form as may be prescribed by the Secretary) with any American employer (as defined in subsection (h)) who desires to have the insurance system established by title II of the Social Security Act extended to service performed outside the United States in the employ of any 1 or more of such employer's foreign affiliates (as defined in paragraph (6)[20]) by all employees who are citizens or residents of the United States, except that the agreement shall not apply to any service performed by, or remuneration paid to, an employee if such service or remuneration would be excluded from the term "employment" or "wages", as defined in this section, had the service been performed in the United States. Such agreement may be amended at any time so as to be made applicable, in the same manner and under the same conditions, with respect to any other foreign affiliate of such American employer. Such agreement shall be applicable with respect to citizens or residents of the United States who, on or after the effective date of the agreement, are employees of and perform services outside the United States for any foreign affiliate specified in the agreement. Such agreement shall provide—

(A) that the American employer shall pay to the Secretary, at such time or times as the Secretary may by regulations prescribe, amounts equivalent to the sum of the taxes which would be imposed by sections 3101 and 3111 (including amounts equivalent to the interest, additions to the taxes, additional amounts, and penalties which would be applicable) with respect to the remuneration which would be wages if the services covered by the agreement constituted employment as defined in this section; and

(B) that the American employer will comply with such regulations relating to payments and reports as the Secretary may prescribe to carry out the purposes of this subsection.

(2) EFFECTIVE PERIOD OF AGREEMENT.—An agreement entered into pursuant to paragraph (1) shall be in effect for the period beginning with the first day of the calendar quarter in which such agreement is entered into or the first day of the succeeding calendar quarter, as may be specified in the agreement; except that in case such agreement is amended to include the services performed for any other affiliate and such amendment is executed after the first month following the first calendar quarter for which the agreement is in effect, the agreement shall be in effect with respect to service performed for such other affiliate only after the calendar quarter in which such amendment is execu-

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[19] P.L. 98-21, §102(b)(2); 97 Stat. 71.

[20] P.L. 101-239, §10201(b)(3), struck out "(8)" and substituted "(6)".

ted. Notwithstanding any other provision of this subsection, the period for which any such agreement is effective with respect to any foreign entity shall terminate at the end of any calendar quarter in which the foreign entity, at any time in such quarter, ceases to be a foreign affiliate as defined in paragraph (6).[21]

(3) No TERMINATION OF AGREEMENT.—No agreement under this subsection may be terminated, either in its entirety or with respect to any foreign affiliate, on or after June 15, 1989.[22]

(4)[23] DEPOSITS IN TRUST FUNDS.—For purposes of section 201 of the Social Security Act, relating to appropriations to the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, such remuneration—

(A) paid for services covered by an agreement entered into pursuant to paragraph (1) as would be wages if the services constituted employment, and

(B) as is reported to the Secretary pursuant to the provisions of such agreement or of the regulations issued under this subsection,

shall be considered wages subject to the taxes imposed by this chapter.

(5)[24] OVERPAYMENTS AND UNDERPAYMENTS.—

(A) If more or less than the correct amount due under an agreement entered into pursuant to this subsection is paid with respect to any payment of remuneration, proper adjustments with respect to the amounts due under such agreement shall be made, without interest, in such manner and at such times as may be required by regulations prescribed by the Secretary.

(B) If an overpayment cannot be adjusted under subparagraph (A), the amount thereof shall be paid by the Secretary, through the Fiscal Service of the Treasury Department, but only if a claim for such overpayment is filed with the Secretary within two years from the time such overpayment was made.

(6)[25] FOREIGN AFFILIATE DEFINED.—For purposes of this subsection and section 210(a) of the Social Security Act—

(A) IN GENERAL.—A foreign affiliate of an American employer is any foreign entity in which such American employer has not less than a 10-percent interest.

(B) DETERMINATION OF 10-PERCENT INTEREST.—For purposes of subparagraph (A), an American employer has a 10-percent interest in any entity if such employer has such an interest directly (or through one or more entities)—

(i) in the case of a corporation, in the voting stock thereof, and

(ii) in the case of any other entity, in the profits thereof.

(7)[26] AMERICAN EMPLOYER AS SEPARATE ENTITY.—Each American employer which enters into an agreement pursuant to paragraph (1) of this subsection shall, for purposes of this subsection and section 6413(c)(2)(C), relating to special refunds in the case of employees of certain foreign entities, be considered an employer in its capacity as a party to such agreement separate and distinct from its identity as a person employing individuals on its own account.

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[21] P.L. 101-239, §10201(a)(1), added this sentence.

[22] P.L. 101-239, §10201(a)(2), struck out the former paragraph (3) and §10201(a)(3), added this paragraph (3).

[23] P.L. 101-239, §10201(a)(2), struck out the former paragraph (4) and §10201(a)(4), redesignated paragraph (6) as paragraph (4).

[24] P.L. 101-239, §10201(a)(2), struck out the former paragraph (5) and §10201(a)(4), redesignated paragraph (7) as paragraph (5).

[25] P.L. 101-239, §10201(a)(4), redesignated paragraph (8) as paragraph (6).

[26] P.L. 101-239, §10201(a)(4), redesignated paragraph (9) as paragraph (7).

(8)[27] REGULATIONS.—Regulations of the Secretary to carry out the purposes of this subsection shall be designed to make the requirements imposed on American employers with respect to services covered by an agreement entered into pursuant to this subsection the same, so far as practicable, as those imposed upon employers pursuant to this title with respect to the taxes imposed by this chapter.

(m) SERVICE IN THE UNIFORMED SERVICES.—For purposes of this chapter—

(1) INCLUSION OF SERVICE.—The term "employment" shall, notwithstanding the provisions of subsection (b) of this section, include--

(A) service performed by an individual as a member of a uniformed service on active duty, but such term shall not include any such service which is performed while on leave without pay, and

(B) service performed by an individual as a member of a uniformed service on inactive duty training.

(2) ACTIVE DUTY.—The term "active duty" means "active duty" as described in section 102 of the Servicemen's and Veterans' Survivor Benefits Act, except that it shall also include "active duty for training" as described in such section.

(3) INACTIVE DUTY TRAINING.—The term "inactive duty training" means "inactive duty training" as described in such section 102.

(n) MEMBER OF A UNIFORMED SERVICE.—For purposes of this chapter, the term "member of a uniformed service" means any person appointed, enlisted, or inducted in a component of the Army, Navy, Air Force, Marine Corps, or Coast Guard (including a reserve component as defined in section 101(27) of title 38, United States Code), or in one of those services without specification of component, or as a commissioned officer of the Coast and Geodetic Survey, the National Oceanic and Atmospheric Administration Corps, or the Regular or Reserve Corps of the Public Health Service, and any person serving in the Army or Air Force under call or conscription. The term includes—

(1) a retired member of any of those services;

(2) a member of the Fleet Reserve or Fleet Marine Corps Reserve;

(3) a cadet at the United States Military Academy, a midshipman at the United States Naval Academy, and a cadet at the United States Coast Guard Academy or United States Air Force Academy;

(4) a member of the Reserve Officers' Training Corps, the Naval Reserve Officers' Training Corps, or the Air Force Reserve

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[27] P.L. 101-239, §10201(a)(4), redesignated paragraph (10) as paragraph (8).

Officers' Training Corps, when ordered to annual training duty for fourteen days or more, and while performing authorized travel to and from that duty; and

(5) any person while en route to or from, or at, a place for final acceptance or for entry upon active duty in the military, naval, or air service—

(A) who has been provisionally accepted for such duty; or

(B) who, under the Military Selective Service Act, has been selected for active military, naval, or air service;

and has been ordered or directed to proceed to such place.

The term does not include a temporary member of the Coast Guard Reserve.

(o) CREW LEADER.—For purposes of this chapter, the term "crew leader" means an individual who furnishes individuals to perform agricultural labor for another person, if such individual pays (either on his own behalf or on behalf of such person) the individuals so furnished by him for the agricultural labor performed by them and if such individual has not entered into a written agreement with such person whereby such individual has been designated as an employee of such person; and such individuals furnished by the crew leader to perform agricultural labor for another person shall be deemed to be the employees of such crew leader. For purposes of this chapter and chapter 2, a crew leader shall, with respect to service performed in furnishing individuals to perform agricultural labor for another person and service performed as a member of the crew, be deemed not to be an employee of such other person.

(p) PEACE CORPS VOLUNTEER SERVICE.—For purposes of this chapter, the term "employment" shall, notwithstanding the provisions of subsection (b) of this section, include service performed by an individual as a volunteer or volunteer leader within the meaning of the Peace Corps Act.

(q) TIPS INCLUDED FOR BOTH EMPLOYEE AND EMPLOYER TAXES.—For purposes of this chapter, tips received by an employee in the course of his employment shall be considered remuneration for such employment (and deemed to have been paid by the employer for purposes of subsections (a) and (b) of section 3111). Such remuneration shall be deemed to be paid at the time a written statement including such tips is furnished to the employer pursuant to section 6053(a) or (if no statement including such tips is so furnished) at the time received; except that, in determining the employer's liability in connection with the taxes imposed by section 3111 with respect to such tips in any case where no statement including such tips was so furnished (or to the extent that the statement so furnished was inaccurate or incomplete), such remuneration shall be deemed for purposes of subtitle F to be paid on the date on which notice and demand for such taxes is made to the employer by the Secretary.

(r) ELECTION OF COVERAGE BY RELIGIOUS ORDERS.—

(1) CERTIFICATE OF ELECTION BY ORDER.—A religious order whose members are required to take a vow of poverty, or any autonomous subdivision of such order, may file a certificate (in such form and manner, and with such official, as may be prescribed by regulations under this chapter) electing to have the insurance system established by title II of the Social Security Act extended to services performed by its members in the

exercise of duties required by such order or such subdivision thereof. Such certificate of election shall provide that—

(A) such election of coverage by such order or subdivision shall be irrevocable;

(B) such election shall apply to all current and future members of such order, or in the case of a subdivision thereof to all current and future members of such order who belong to such subdivision;

(C) all services performed by a member of such an order or subdivision in the exercise of duties required by such order or subdivision shall be deemed to have been performed by such member as an employee of such order or subdivision; and

(D) the wages of each member, upon which such order or subdivision shall pay the taxes imposed by sections 3101 and 3111, will be determined as provided in subsection (i)(4).

(2) DEFINITION OF MEMBER.—For purposes of this subsection, a member of a religious order means any individual who is subject to a vow of poverty as a member of such order and who performs tasks usually required (and to the extent usually required) of an active member of such order and who is not considered retired because of old age or total disability.

(3) EFFECTIVE DATE FOR ELECTION.—(A) A certificate of election of coverage shall be in effect, for purposes of subsection (b)(8) and for purposes of section 210(a)(8) of the Social Security Act, for the period beginning with whichever of the following may be designated by the order or subdivision thereof:

(i) the first day of the calendar quarter in which the certificate is filed,

(ii) the first day of the calendar quarter succeeding such quarter, or

(iii) the first day of any calendar quarter preceding the calendar quarter in which the certificate is filed, except that such date may not be earlier than the first day of the twentieth calendar quarter preceding the quarter in which such certificate is filed.

Whenever a date is designated under clause (iii), the election shall apply to services performed before the quarter in which the certificate is filed only if the member performing such services was a member at the time such services were performed and is living on the first day of the quarter in which such certificate is filed.

(B) If a certificate of election filed pursuant to this subsection is effective for one or more calendar quarters prior to the quarter in which such certificate is filed, then—

(i) for purposes of computing interest and for purposes of section 6651 (relating to addition to tax for failure to file tax return), the due date for the return and payment of the tax for such prior calendar quarters resulting from the filing of such certificate shall be the last day of the calendar month following the calendar quarter in which the certificate is filed; and

(ii) the statutory period for the assessment of such tax shall not expire before the expiration of 3 years from such due date.

(s) CONCURRENT EMPLOYMENT BY TWO OR MORE EMPLOYERS.—For purposes of sections 3102, 3111, and 3121(a)(1), if two or more related corporations concurrently employ the same individual and compensate such individual through a common paymaster which is one of such corporations, each such corporation shall be considered to have paid as remuneration to such individual only the amounts actually disbursed by it to such individual and shall not be considered to have paid as remuneration to such individual amounts actually disbursed to such individual by another of such corporations.

[(t) Repealed.[28]]

(u) APPLICATION OF HOSPITAL INSURANCE TAX TO FEDERAL, STATE, and LOCAL EMPLOYMENT.—

(1) FEDERAL EMPLOYMENT.—For purposes of the taxes imposed by sections 3101(b) and 3111(b), subsection (b) shall be applied without regard to paragraph (5) thereof.

(2) STATE AND LOCAL EMPLOYMENT.—For purposes of the taxes imposed by sections 3101(b) and 3111(b)—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), subsection (b) shall be applied without regard to paragraph (7) thereof.

(B) EXCEPTION FOR CERTAIN SERVICES.—Service shall not be treated as employment by reason of subparagraph (A) if—

(i) the service is included under an agreement under section 218 of the Social Security Act, or

(ii) the service is performed—

(I) by an individual who is employed by a State or political subdivision thereof to relieve him from unemployment,

(II) in a hospital, home, or other institution by a patient or inmate thereof as an employee of a State or political subdivision thereof or of the District of Columbia,

(III) by an individual, as an employee of a State or political subdivision thereof or of the District of Columbia, serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency,

(IV) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or a medical or dental resident in training,

(V) by an election official or election worker if the remuneration paid in a calendar year for such service is less than $100, or

(VI) by an individual in a position described in section 1402(c)(2)(E).

As used in this subparagraph, the terms "State" and "political subdivision" have the meanings given those terms in section 218(b) of the Social Security Act.

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[28] P.L. 100-203, §9006(b)(2); 101 Stat. 1330-289.

(C) EXCEPTION FOR CURRENT EMPLOYMENT WHICH CONTINUES.—Service performed for an employer shall not be treated as employment by reason of subparagraph (A) if—

(i) such service would be excluded from the term "employment" for purposes of this chapter if subparagraph (A) did not apply;

(ii) such service is performed by an individual—

(I) who was performing substantial and regular service for remuneration for that employer before April 1, 1986,

(II) who is a bona fide employee of that employer on March 31, 1986, and

(III) whose employment relationship with that employer was not entered into for purposes of meeting the requirements of this subparagraph; and

(iii) the employment relationship with that employer has not been terminated after March 31, 1986.

(D) TREATMENT OF AGENCIES AND INSTRUMENTALITIES.—For purposes of subparagraph (C), under regulations—

(i) All agencies and instrumentalities of a State (as defined in section 218(b) of the Social Security Act) or of the District of Columbia shall be treated as a single employer.

(ii) All agencies and instrumentalities of a political subdivision of a State (as so defined) shall be treated as a single employer and shall not be treated as described in clause (i).

(3) MEDICARE QUALIFIED GOVERNMENT EMPLOYMENT.—For purposes of this chapter, the term "medicare qualified government employment" means service which—

(A) is employment (as defined in subsection (b)) with the application of paragraphs (1) and (2), but

(B) would not be employment (as so defined) without the application of such paragraphs.

(v) TREATMENT OF CERTAIN DEFERRED COMPENSATION AND SALARY REDUCTION ARRANGEMENTS.—

(1) CERTAIN EMPLOYER CONTRIBUTIONS TREATED AS WAGES.—Nothing in any paragraph of subsection (a) (other than paragraph (1)) shall exclude from the term "wages"—

(A) any employer contribution under a qualified cash or deferred arrangement (as defined in section 401(k)) to the extent not included in gross income by reason of section 402(a)(8), or

(B) any amount treated as an employer contribution under section 414(h)(2) where the pickup referred to in such section is pursuant to a salary reduction agreement (whether evidenced by a written instrument or otherwise).

(2) TREATMENT OF CERTAIN NONQUALIFIED DEFERRED COMPENSATION PLANS.—

(A) IN GENERAL.—Any amount deferred under a nonqualified deferred compensation plan shall be taken into account for purposes of this chapter as of the later of—

(i) when the services are performed, or

(ii) when there is no substantial risk of forfeiture of the rights to such amount.

The preceding sentence shall not apply to any excess parachute payment (as defined in section 280G(b)).

(B) Taxed only once.—Any amount taken into account as wages by reason of subparagraph (A) (and the income attributable thereto) shall not thereafter be treated as wages for purposes of this chapter.

(C) Nonqualified deferred compensation plan.—For purposes of this paragraph, the term "nonqualified deferred compensation plan" means any plan or other arrangement for deferral of compensation other than a plan described in subsection (a)(5).

(3) Exempt governmental deferred compensation plan.—For purposes of subsection (a)(5), the term "exempt governmental deferred compensation plan" means any plan providing for deferral of compensation established and maintained for its employees by the United States, by a State or political subdivision thereof, or by an agency or instrumentality of any of the foregoing. Such term shall not include—

(A) any plan to which section 83, 402(b), 403(c), 457(a), or 457(f)(1) applies,

(B) any annuity contract described in section 403(b), and

(C) the Thrift Savings Fund (within the meaning of subchapter III of chapter 84 of title 5, United States Code).

(w) Exemption of Churches and Qualified Church-Controlled Organizations.—

(1) General rule.—Any church or qualified church-controlled organization (as defined in paragraph (3)) may make an election within the time period described in paragraph (2), in accordance with such procedures as the Secretary determines to be appropriate, that services performed in the employ of such church or organization shall be excluded from employment for purposes of title II of the Social Security Act and this chapter. An election may be made under this subsection only if the church or qualified church-controlled organization states that such church or organization is opposed for religious reasons to the payment of the tax imposed under section 3111.

(2) Timing and duration of election.—An election under this subsection must be made prior to the first date, more than 90 days after July 18, 1984, on which a quarterly employment tax return for the tax imposed under section 3111 is due, or would be due but for the election, from such church or organization. An election under this subsection shall apply to current and future employees, and shall apply to service performed after December 31, 1983. The election may be revoked by the church or organization under regulations prescribed by the Secretary. The election shall be revoked by the Secretary if such church or organization fails to furnish the information required under section 6051 to the Secretary for a period of 2 years or more with respect to remuneration paid for such services by such church or organization, and, upon request by the Secretary, fails to furnish all such previously unfurnished information for the period covered by the election. Any revocation under the preceding

sentence shall apply retroactively to the beginning of the 2-year period for which the information was not furnished.

(3) Definitions.—

(A) For purposes of this subsection, the term "church" means a church, a convention or association of churches, or an elementary or secondary school which is controlled, operated, or principally supported by a church or by a convention or association of churches.

(B) For purposes of this subsection, the term "qualified church-controlled organization" means any church-controlled tax-exempt organization described in section 501(c)(3), other than an organization which—

(i) offers goods, services, or facilities for sale, other than on an incidental basis, to the general public, other than goods, services, or facilities which are sold at a nominal charge which is substantially less than the cost of providing such goods, services, or facilities; and

(ii) normally receives more than 25 percent of its support from either (I) governmental sources, or (II) receipts from admissions, sales of merchandise, performance of services, or furnishing of facilities, in activities which are not unrelated trades or businesses, or both.

(x) Applicable contribution base.—For purposes of this chapter—

(1) Old-Age, survivors, and disability insurance.—For purposes of the taxes imposed by sections 3101(a) and 3111(a), the applicable contribution base for any calendar year is the contribution and benefit base determined under section 230 of the Social Security Act for such calendar year.

(2) Hospital insurance.—For purposes of the taxes imposed by section 3101(b) and 3111(b), the applicable contribution base is

(A) $125,000 for calendar year 1991, and

(B) for any calendar year after 1991, the applicable contribution base for the preceding year adjusted in the same manner as is used in adjusting the contribution and benefit base under section 230(b) of the Social Security Act.[29]

SEC. 3122. FEDERAL SERVICE.

In the case of the taxes imposed by this chapter with respect to service performed in the employ of the United States or in the employ of any instrumentality which is wholly owned by the United States, including such service which is medicare qualified government employment (as defined in section 3121(u)(3)), including service, performed as a member of a uniformed service, to which the provisions of section 3121(m)(1) are applicable, and including service, performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act, to which the provisions of section 3121(p) are applicable, the determination of the amount of remuneration for such service, and the return and payment of the taxes imposed by this chapter, shall be made by the head of the Federal agency or instrumentality having the control of such service, or by such agents as such head may designate. Nothing in this paragraph shall be construed to affect the Secretary's authority to determine under subsections (a) and (b) of section 3121 whether any such service constitutes employment, the periods of such employment, and whether remuneration paid for any such service constitutes wages. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to such service without regard to the applicable contribution base limitation[30] in section 3121(a)(1), and he shall not be required to obtain a refund of the tax paid under section 3111 on that part of the remuneration not included in wages by reason of section 3121(a)(1). Payments of the tax imposed under section 3111 with respect to service, performed by an individual as a member of a uniformed service, to which the provisions of section 3121(m)(1) are applicable, shall be made from appropriations available for the pay of members of such uniformed service. The provisions of this section shall be applicable in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense, at installations of the Department of Defense for the comfort, pleasure, contentment, and mental and physical improvement of personnel of such Department; and for purposes of this section the Secretary of Defense shall be deemed to be the head of such instrumentality. The provisions of this section shall be applicable also in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Transportation, at installations of the Coast Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard; and for purposes of this section the Secretary of Transportation shall be deemed to be the head of such instrumentality.

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[29] P.L. 101-140, §203(a)(2), repealed subsection (x), effective November 10, 1988.
P.L. 101-508, §11331(a)(2), added this subsection (x) applicable to 1991 and later calendar years.

SEC. 3123. DEDUCTIONS AS CONSTRUCTIVE PAYMENTS.

Whenever under this chapter or any act of Congress, or under the law of any State, an employer is required or permitted to deduct any amount from the remuneration of an employee and to pay the amount deducted to the United States, a State, or any political subdivision thereof, then for purposes of this chapter the amount so deducted shall be considered to have been paid to the employee at the time of such deduction.

SEC. 3124. ESTIMATE OF REVENUE REDUCTION.

The Secretary at intervals of not longer than 3 years shall estimate the reduction in the amount of taxes collected under this chapter by reason of the operation of section 3121(b)(9) and shall include such estimate in his annual report.

SEC. 3125. RETURNS IN THE CASE OF GOVERNMENTAL EMPLOYEES IN STATES, GUAM, AMERICAN SAMOA, AND THE DISTRICT OF COLUMBIA.

(a) STATES.—Except as otherwise provided in this section, in the case of the taxes imposed by sections 3101(b) and 3111(b) with respect to service performed in the employ of a State or any political subdivision thereof (or any instrumentality of any one or more of the foregoing which is wholly owned thereby), the return and payment of such taxes may be made by the head of the agency or instrumentality having the control of such service, or by such agents as such head may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to the service of such individuals without regard to the applicable contribution base limitation[31] in section 3121(a)(1).

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[30] P.L. 101-508, §11331(d)(2), struck out "contribution and benefit base limitation" and substituted "applicable contribution base limitation".

(b) GUAM.—The return and payment of the taxes imposed by this chapter on the income of individuals who are officers or employees of the Government of Guam or any political subdivision thereof or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, and those imposed on such Government or political subdivision or instrumentality with respect to having such individuals in its employ, may be made by the Governor of Guam or by such agents as he may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to the service of such individuals without regard to the applicable contribution base limitation[32] in section 3121(a)(1).

(c) AMERICAN SAMOA.—The return and payment of the taxes imposed by this chapter on the income of individuals who are officers or employees of the Government of American Samoa or any political subdivision thereof or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, and those imposed on such Government or political subdivision or instrumentality with respect to having such individuals in its employ, may be made by the Governor of American Samoa or by such agents as he may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to the service of such individuals without regard to the applicable contribution base limitation[33] in section 3121(a)(1).

(d) DISTRICT OF COLUMBIA.—In the case of the taxes imposed by this chapter with respect to service performed in the employ of the District of Columbia or in the employ of any instrumentality which is wholly owned thereby, the return and payment of the taxes may be made by the Mayor of the District of Columbia or such agents as he may designate. The person making such return may, for convenience of administration, make payments of the tax imposed by section 3111 with respect to such service without regard to the applicable contribution base limitation[34] in section 3121(a)(1).

SEC. 3126. RETURN AND PAYMENT BY GOVERNMENTAL EMPLOYER.

If the employer is a State or political subdivision thereof, or an agency or instrumentality of any one or more of the foregoing, the return of the amount deducted and withheld upon any wages under section 3101 and the amount of the tax imposed by section 3111 may be made by any officer or employee of such State or political subdivision or such agency or instrumentality, as the case may be, having control of the payment of such wages, or appropriately designated for that purpose.

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[31] P.L. 101-508, §11331(d)(2), struck out "contribution and benefit base limitation" and substituted "applicable contribution base limitation".

[32] P.L. 101-508, §11331(d)(2), struck out "contribution and benefit base limitation" and substituted "applicable contribution base limitation".

[33] P.L. 101-508, §11331(d)(2), struck out "contribution and benefit base limitation" and substituted "applicable contribution base limitation".

[34] P.L. 101-508, §11331(d)(2), struck out "contribution and benefit base limitation" and substituted "applicable contribution base limitation".

SEC. 3127. EXEMPTION FOR EMPLOYERS AND THEIR EMPLOYEES WHERE BOTH ARE MEMBERS OF RELIGIOUS FAITHS OPPOSED TO PARTICIPATION IN SOCIAL SECURITY ACT PROGRAMS.

(a) In General.—Notwithstanding any other provision of this chapter (and under regulations prescribed to carry out this section), in any case where—

(1) an employer (or, if the employer is a partnership, each partner therein)[35] is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sect or division as described in such section, and has filed and had approved under subsection (b) an application (in such form and manner, and with such official, as may be prescribed by such regulations) for an exemption from the taxes imposed by section 3111, and

(2) an employee of such employer who is also a member of such a religious sect or division and an adherent of its established tenets or teachings has filed and had approved under subsection (b) an identical application for exemption from the taxes imposed by section 3101,

such employer shall be exempt from the taxes imposed by section 3111 with respect to wages paid to each of the employees thereof[36] who meets the requirements of paragraph (2) and each such employee shall be exempt from the taxes imposed by section 3101 with respect to such wages paid to him by such employer.

(b) Approval of Application.—An application for exemption filed by an employer (or a partner)[37] under subsection (a)(1) or by an employee under subsection (a)(2) shall be approved only if—

(1) such application contains or is accompanied by the evidence described in section 1402(g)(1)(A) and a waiver described in section 1402(g)(1)(B),

(2) the Secretary of Health and Human Services makes the findings (with respect to such sect or division) described in section 1402(g)(1)(C), (D), and (E), and

(3) no benefit or other payment referred to in section 1402(g)(1)(B) became payable (or, but for section 203 or 222(b) of the Social Security Act, would have become payable) to the individual filing the application at or before the time of such filing.

(c) Effective Period of Exemption.—An exemption granted under this section to any employer with respect to wages paid to any of the employees thereof[38], or granted to any such employee, shall apply with respect to wages paid by such employer during the period—

(1) commencing with the first day of the first calendar quarter, after the quarter in which such application is filed, throughout

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[35] P.L. 101-239, §10204(b)(1)(A), inserted "(or, if the employer is a partnership, each partner therein)".

[36] P.L. 101-239, §10204(b)(1)(B), struck out "his employees" and substituted "the employees thereof".

[37] P.L. 101-239, §10204(b)(1)(C), inserted "(or a partner)".

[38] P.L. 101-239, §10204(b)(1)(D), struck out "his employees" and substituted "the employees thereof".

which such employer (or, if the employer is a partnership, each partner therein)[39] or employee meets the applicable requirements specified in subsections (a) and (b), and

(2) ending with the last day of the calendar quarter preceding the first calendar quarter thereafter in which (A) such employer (or, if the employer is a partnership, any partner therein) or the employee involved does not[40] meet the applicable requirements of subsection (a), or (B) the sect or division thereof of which such employer (or, if the employer is a partnership, any partner therein)[41] or employee is a member is found by the Secretary of Health and Human Services to have ceased to meet the requirements of subsection (b)(2).

SEC. 3128. SHORT TITLE.

This chapter may be cited as the "Federal Insurance Contributions Act."

CHAPTER 22—RAILROAD RETIREMENT TAX ACT

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SUBCHAPTER A—TAX ON EMPLOYEES

SEC. 3201. RATE OF TAX.

(a) TIER 1 TAX.—In addition to other taxes, there is hereby imposed on the income of each employee a tax equal to the applicable[42] percentage of the compensation received during any calendar year by such employee for services rendered by such employee. For purposes of the preceding sentence, the term "applicable percentage" means the percentage equal to the sum of the rates of tax in effect under subsections (a) and (b) of section 3101 for the calendar year.[43]

(b) TIER 2 TAX.—In addition to other taxes, there is hereby imposed on the income of each employee a tax equal to 4.90 percent of the compensation received during any calendar year by such employee for services rendered by such employee.

(c) CROSS REFERENCE.—

For application of different contribution bases with respect to the taxes imposed by subsections (a) and (b), see section 3231(e)(2).

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SEC. 3231. DEFINITIONS.

(a) EMPLOYER.—For purposes of this chapter, the term "employer" means any carrier (as defined in subsection (g)), and any company which is directly or indirectly owned or controlled by one or more such carriers or under common control therewith, and which operates any equipment or facility or performs any service (except trucking service, casual service, and the casual operation of equipment or facilities) in connection with the transportation of passengers or property by railroad, or the receipt, delivery, elevation, transfer in transit, refrigeration or icing, storage, or handling of property transported by railroad, and any receiver, trustee, or other individual or body, judicial or otherwise, when in the possession of the property or operating all or any part of the business of any such employer; except that the term "employer" shall not include any street, interurban, or suburban electric railway, unless such railway is operating as a part of a general steam-railroad system of transportation, but shall not exclude any part of the general steam-railroad system of transportation now or hereafter operated by any other motive power. The Interstate Commerce Commission is hereby authorized and directed upon request of the Secretary, or upon complaint of any party interested, to determine after hearing whether any line operated by electric power falls within the terms of this exception. The term "employer" shall also include railroad associations, traffic associations, tariff bureaus, demurrage bureaus, weighing and inspection bureaus, collection agencies and other associations, bureaus, agencies, or organizations controlled and maintained wholly or principally by two or more employers as hereinbefore defined and engaged in the performance of services in connection with or incidental to railroad transportation; and railway labor organizations, national in scope, which have been or may be organized in accordance with the provisions of the Railway Labor Act, as amended (45 U.S.C., chapter 8), and their State and National legislative committees and their general committees and their insurance departments and their local lodges and divisions, established pursuant to the constitutions and bylaws of such organizations. The term "employer" shall not include any company by reason of its being engaged in the mining of coal, the supplying of coal to an employer where delivery is not beyond the mine tipple, and the operation of equipment or facilities therefor, or in any of such activities.

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[39] P.L. 101-239, §10204(b)(1)(E), inserted "(or, if the employer is a partnership, each partner therein)".

[40] P.L. 101-239, §10204(b)(1)(F), struck out "or the employee involved ceases to" and substituted "(or, if the employer is a partnership, any partner therein) or the employee involved does not".

[41] P.L. 101-239, §10204(b)(1)(F), inserted "(or, if the employer is a partnership, any partner therein)".

[42] P.L. 101-508, §5125(a)(1), struck out "following" and substituted "applicable".

[43] P.L. 101-508, §5125(a)(2), struck out "employee:" and the table that followed and substituted "employee. For purposes of the preceding sentence, the term "applicable percentage" means the percentage equal to the sum of the rates of tax in effect under subsections (a) and (b) of section 3101 for the calendar year".

(b) EMPLOYEE.—For purposes of this chapter, the term "employee" means any individual in the service of one or more employers for compensation; except that the term "employee" shall include an employee of a local lodge or division defined as an employer in subsection (a) only if he was in the service of or in the employment relation to a carrier on or after August 29, 1935. An individual shall be deemed to have been in the employment relation to a carrier on August 29, 1935, if—

(1) he was on that date on leave of absence from his employment, expressly granted to him by the carrier by whom he was employed, or by a duly authorized representative of such carrier, and the grant of such leave of absence was established to the satisfaction of the Railroad Retirement Board before July 1947; or

(2) he was in the service of a carrier after August 29, 1935, and before January 1946 in each of 6 calendar months, whether or not consecutive; or

(3) before August 29, 1935, he did not retire and was not retired or discharged from the service of the last carrier by whom he was employed or its corporate or operating successor, but—

(A) solely by reason of his physical or mental disability he ceased before August 29, 1935, to be in the service of such carrier and thereafter remained continuously disabled until he attained age 65 or until August 1945, or

(B) solely for such last stated reason a carrier by whom he was employed before August 29, 1935, or a carrier who is its successor did not on or after August 29, 1935, and before August 1945 call him to return to service, or

(C) if he was so called he was solely for such reason unable to render service in 6 calendar months as provided in paragraph (2); or

(4) he was on August 29, 1935, absent from the service of a carrier by reason of a discharge which, within 1 year after the effective date thereof, was protested, to an appropriate labor representative or to the carrier, as wrongful, and which was followed within 10 years of the effective date thereof by his reinstatement in good faith to his former service with all his seniority rights;

except that an individual shall not be deemed to have been on August 29, 1935, in the employment relation to a carrier if before that date he was granted a pension or gratuity on the basis of which a pension was awarded to him pursuant to section 6 of the Railroad Retirement Act of 1937 (45 U.S.C. 228f), or if during the last payroll period before August 29, 1935, in which he rendered service to a carrier he was not in the service of an employer, in accordance with subsection (d), with respect to any service in such payroll period, or if he could have been in the employment relation to an employer only by reason of his having been, either before or after August 29, 1935, in the service of a local lodge or division defined as an employer in subsection (a). The term "employee" includes an officer of an employer. The term "employee" shall not include any individual while such individual is engaged in the physical operations consisting of the mining of coal, the preparation of coal, the handling (other than movement by rail with standard railroad locomotives) of coal not beyond the mine tipple, or the loading of coal at the tipple.

(c) EMPLOYEE REPRESENTATIVE.—For purposes of this chapter, the term "employee representative" means any officer or official representative of a railway labor organization other than a labor organization included in the term "employer" as defined in subsection (a), who before or after June 29, 1937, was in the service of an employer as defined in subsection (a) and who is duly authorized and designated to represent employees in accordance with the Railway Labor Act (45 U.S.C., chapter 8), as amended, and any individual who is regularly assigned to or regularly employed by such officer or official representative in connection with the duties of his office.

(d) SERVICE.—For purposes of this chapter, an individual is in the service of an employer whether his service is rendered within or without the United States, if—

(1) he is subject to the continuing authority of the employer to supervise and direct the manner of rendition of his service, or he

is rendering professional or technical services and is integrated into the staff of the employer, or he is rendering, on the property used in the employer's operations, other personal services the rendition of which is integrated into the employer's operations, and

(2) he renders such service for compensation;

except that an individual shall be deemed to be in the service of an employer, other than a local lodge or division or a general committee of a railway-labor-organization employer, not conducting the principal part of its business in the United States, only when he is rendering service to it in the United States; and an individual shall be deemed to be in the service of such a local lodge or division only if—

(3) all, or substantially all, the individuals constituting its membership are employees of an employer conducting the principal part of its business in the United States; or

(4) the headquarters of such local lodge or division is located in the United States;

and an individual shall be deemed to be in the service of such a general committee only if—

(5) he is representing a local lodge or division described in paragraph (3) or (4) immediately above; or

(6) all, or substantially all, the individuals represented by it are employees of an employer conducting the principal part of its business in the United States; or

(7) he acts in the capacity of a general chairman or an assistant general chairman of a general committee which represents individuals rendering service in the United States to an employer, but in such case if his office or headquarters is not located in the United States and the individuals represented by such general committee are employees of an employer not conducting the principal part of its business in the United States, only such proportion of the remuneration for such service shall be regarded as compensation as the proportion which the mileage in the United States under the jurisdiction of such general committee bears to the total mileage under its jurisdiction, unless such mileage formula is inapplicable, in which case such other formula as the Railroad Retirement Board may have prescribed pursuant to section 1(c) of the Railroad Retirement Act of 1937 (45 U.S.C. 228a) shall be applicable, and if the application of such mileage formula, or such other formula as the Board may prescribe, would result in the compensation of the individual being less than 10 percent of his remuneration for such service, no part of such remuneration shall be regarded as compensation;

Provided however, That an individual not a citizen or resident of the United States shall not be deemed to be in the service of an employer when rendering service outside the United States to an employer who is required under the laws applicable in the place where the service is rendered to employ therein, in whole or in part, citizens or residents thereof; and the laws applicable on August 29, 1935, in the place where the service is rendered shall be deemed to have been applicable there at all times prior to that date.

(e) COMPENSATION.—For purposes of this chapter—

(1) The term "compensation" means any form of money remuneration paid to an individual for services rendered as an employee to one or more employers. Such term does not include (i) the amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of his dependents under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally and their dependents) or for a class or classes of his employees (or for a class or classes of his employees and their dependents), on account of sickness or accident disability or medical or hospitalization expenses in connection with sickness or accident disability or death, except that this clause does not apply to a payment for group-term life insurance to the extent that such payment is includible in the gross income of the employee[44], (ii) tips (except as is provided under paragraph (3)),[45] (iii) an amount paid specifically—either as an advance, as reimbursement or allowance—for traveling or other bona fide and necessary expenses incurred or reasonably expected to be incurred in the business of the employer provided any such payment is identified by the employer either by a separate payment or by specifically indicating the separate amounts where both wages and expense reimbursement or allowance are combined in a single payment, or (iv) any remuneration which would not (if chapter 21 applied to such remuneration) be treated as wages (as defined in section 3121(a)) by reason of section 3121(a)(5)[46]. Such term does not include remuneration for service which is performed by a nonresident alien individual for the period he is temporarily present in the United States as a nonimmigrant under subparagraph (F), (J), or (M) of section 101(a)(15) of the Immigration and Nationality Act, as amended, and which is performed to carry out the purpose specified in subparagraph (F), (J), or (M), as the case may be. For the purpose of determining the amount of taxes under sections 3201 and 3221, compensation earned in the service of a local lodge or division of a railway-labor-organization employer shall be disregarded with respect to any calendar month if the amount thereof is less than $25. Compensation for service as a delegate to a national or international convention of a railway labor organization defined as an "employer" in subsection (a) of this section shall be disregarded for purposes of determining the amount of taxes due pursuant to this chapter if the individual rendering such service has not previously rendered service, other than as such a delegate, which may be included in his "years of service" for purposes of the Railroad Retirement Act. Nothing in the regulations prescribed for purposes of chapter 24 (relating to wage withholding) which provides an exclusion from "wages" as used in such chapter shall be construed to require a similar exclusion from "compensation" in regulations prescribed for purposes of this chapter.[47]

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[44] P.L. 101-239, §10205(a), inserted "or death, except that this clause does not apply to a payment for group-term life insurance to the extent that such payment is includible in the gross income of the employee".

[45] P.L. 101-239, §10206(a), struck out "or".

[46] P.L. 101-239, §10206(a), added ", or" and clause (iv).

[47] P.L. 101-239, §10207(b), added this sentence.

(2) APPLICATION OF CONTRIBUTION BASES.—

(A) COMPENSATION IN EXCESS OF APPLICABLE BASE EXCLUDED.—

(i) IN GENERAL.—The term "compensation" does not include that part of remuneration paid during any calendar year to an individual by an employer after remuneration equal to the applicable base has been paid during such calendar year to such individual by such employer for services rendered as an employee to such employer.

(ii) REMUNERATION NOT TREATED AS COMPENSATION EXCLUDED.—There shall not be taken into account under clause (i) remuneration which (without regard to clause (i)) is not treated as compensation under this subsection.

(B) APPLICABLE BASE.—

(i) TIER 1 TAXES.—

(I) IN GENERAL.—Except as provided in subclause (II) of this clause and in clause (ii), the term "applicable base" means for any calendar year the contribution and benefit base determined under section 230 of the Social Security Act for such calendar year.

(II) HOSPITAL INSURANCE TAXES.—For purposes of applying so much of the rate applicable under section 3201(a) or 3221(a) (as the case may be) as does not exceed the rate of tax in effect under section 3101(b), and for purposes of applying so much of the rate of tax applicable under section 3211(a)(1) as does not exceed the rate of tax in effect under section 1401(b), the term "applicable base" means for any calendar year the applicable contribution base determined under section 3121(x)(2) for such calendar year.[48]

(ii) TIER 2 TAXES, ETC.—For purposes of—

(I) the taxes imposed by sections 3201(b), 3211(a)(2), and 3221(b), and

(II) computing average monthly compensation under section 3(j) of the Railroad Retirement Act of 1974 (except with respect to annuity amounts determined under subsection (a) or (f)(3) of section 3 of such Act),

clause (2) of the first sentence, and the second sentence, of subsection (c) of section 230 of the Social Security Act shall be disregarded.

(C) SUCCESSOR EMPLOYERS.—For purposes of this paragraph, the second sentence of section 3121(a)(1) (relating to successor employers) shall apply, except that—

(i) the term "services" shall be substituted for "employment" each place it appears,

(ii) the term "compensation" shall be substituted for "remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection)" each place it appears, and

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[48] P.L. 101-508, §11331(c), amended clause (i) in its entirety.

(iii) the terms "employer", "services", and "compensation" shall have the meanings given such terms by this section.

(3) Solely for purposes of the taxes imposed by section 3201 and other provisions of this chapter insofar as they relate to such taxes, the term "compensation" also includes cash tips received by an employee in any calendar month in the course of his employment by an employer unless the amount of such cash tips is less than $20.

(4)(A) For purposes of applying sections 3201(a), 3211(a)(1), and 3221(a), in the case of payments made to an employee or any of his dependents on account of sickness or accident disability, clause (i) of the second sentence of paragraph (1) shall exclude from the term "compensation" only—

(i) payments which are received under a workmen's compensation law, and

(ii) benefits received under the Railroad Retirement Act of 1974.

(B) Notwithstanding any other provision of law, for purposes of the sections specified in subparagraph (A), the term "compensation" shall include benefits paid under section 2(a) of the Railroad Unemployment Insurance Act for days of sickness, except to the extent that such sickness (as determined in accordance with standards prescribed by the Railroad Retirement Board) is the result of on-the-job injury.

(C) Under regulations prescribed by the Secretary, subparagraphs (A) and (B) shall not apply to payments made after the expiration of a 6-month period comparable to the 6-month period described in section 3121(a)(4).

(D) Except as otherwise provided in regulations prescribed by the Secretary, any third party which makes a payment included in compensation solely by reason of subparagraph (A) or (B) shall be treated for purposes of this chapter as the employer with respect to such compensation.

(5) The term "compensation" shall not include any benefit provided to or on behalf of an employee if at the time such benefit is provided it is reasonable to believe that the employee will be able to exclude such benefit from income under section 74(c), 117, or 132.

(6) The term "compensation" shall not include any payment made, or benefit furnished, to or for the benefit of an employee if at the time of such payment or such furnishing it is reasonable to believe that the employee will be able to exclude such payment or benefit from income under section 127.

(7) The term "compensation" shall not include any contribution, payment, or service provided by an employer which may be excluded from the gross income of an employee, his spouse, or his dependents, under the provisions of section 120 (relating to amounts received under qualified group legal services plans).

(8)[49] **TREATMENT OF CERTAIN DEFERRED COMPENSATION AND SALARY REDUCTION ARRANGEMENTS.—**

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[49] P.L. 101-140, §203(a)(2), repealed the former paragraph (8).
P.L. 101-239, §10206(b), added paragraph (9).
P.L. 101-508, §11704(a)(19), redesignated paragraph (9) as paragraph (8).

(A) CERTAIN EMPLOYER CONTRIBUTIONS TREATED AS COMPENSATION.—Nothing in any paragraph of this subsection (other than paragraph (2)) shall exclude from the term "compensation" any amount described in subparagraph (A) or (B) of section 3121(v)(1).

(B) TREATMENT OF CERTAIN NONQUALIFIED DEFERRED COMPENSATION.—The rules of section 3121(v)(2) which apply for purposes of chapter 21 shall also apply for purposes of this chapter.

(9)[50] MEALS AND LODGING.—The term "compensation" shall not include the value of meals or lodging furnished by or on behalf of the employer if at the time of such furnishing it is reasonable to believe that the employee will be able to exclude such items from income under section 119.

(f) COMPANY.—For purposes of this chapter, the term "company" includes corporations, associations, and joint-stock companies.

(g) CARRIER.—For purposes of this chapter, the term "carrier" means an express carrier, sleeping car carrier, or rail carrier providing transportation subject to subchapter I of chapter 105 of title 49.

(h) TIPS CONSTITUTING COMPENSATION, TIME DEEMED PAID.—For purposes of this chapter, tips which constitute compensation for purposes of the taxes imposed by section 3201 shall be deemed to be paid at the time a written statement including such tips is furnished to the employer pursuant to section 6053(a) or (if no statement including such tips is so furnished) at the time received.

(i) CONCURRENT EMPLOYMENT BY 2 OR MORE EMPLOYERS.—For purposes of this chapter, if 2 or more related corporations which are employers concurrently employ the same individual and compensate such individual through a common paymaster which is 1 of such corporations, each such corporation shall be considered to have paid as remuneration to such individual only the amounts actually disbursed by it to such individual and shall not be considered to have paid as remuneration to such individual amounts actually disbursed to such individual by another of such corporations.

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CHAPTER 23—FEDERAL UNEMPLOYMENT TAX ACT

SEC. 3301. RATE OF TAX.

There is hereby imposed on every employer (as defined in section 3306(a)) for each calendar year an excise tax, with respect to having individuals in his employ, equal to—

(1) 6.2 percent in the case of calendar years 1988 through 1995[51]; or

(2) 6.0 percent in the case of calendar year 1996[52] and each calendar year thereafter;

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[50] P.L. 101-239, §10207(a), added paragraph (10).
P.L. 101-508, §11704(a)(19), redesignated paragraph (10) as paragraph (9).

[51] P.L. 101-508, §11333(1), struck out "1988, 1989, and 1990" and substituted "1988 through 1995".

[52] P.L. 101-508, §11333(2), struck out "1991" and substituted "1996".

of the total wages (as defined in section 3306(b)) paid by him during the calendar year with respect to employment (as defined in section 3306(c)).

SEC. 3302. CREDITS AGAINST TAX.

(a) CONTRIBUTIONS TO STATE UNEMPLOYMENT FUNDS.—

(1) The taxpayer may, to the extent provided in this subsection and subsection (c), credit against the tax imposed by section 3301 the amount of contributions paid by him into an unemployment fund maintained during the taxable year under the unemployment compensation law of a State which is certified as provided in section 3304 for the 12-month period ending on October 31 of such year.

(2) The credit shall be permitted against the tax for the taxable year only for the amount of contributions paid with respect to such taxable year.

(3) The credit against the tax for any taxable year shall be permitted only for contributions paid on or before the last day upon which the taxpayer is required under section 6071 to file a return for such year; except that credit shall be permitted for contributions paid after such last day, but such credit shall not exceed 90 percent of the amount which would have been allowable as credit on account of such contributions had they been paid on or before such last day.

(4) Upon the payment of contributions into the unemployment fund of a State which are required under the unemployment compensation law of that State with respect to remuneration on the basis of which, prior to such payment into the proper fund, the taxpayer erroneously paid an amount as contributions under another unemployment compensation law, the payment into the proper fund shall, for purposes of credit against the tax, be deemed to have been made at the time of the erroneous payment. If, by reason of such other law, the taxpayer was entitled to cease paying contributions with respect to services subject to such other law, the payment into the proper fund shall, for purposes of credit against the tax, be deemed to have been made on the date the return for the taxable year was filed under section 6071.

(5) In the case of wages paid by the trustee of an estate under title 11 of the United States Code, if the failure to pay contributions on time was without fault by the trustee, paragraph (3) shall be applied by substituting "100 percent" for "90 percent".

(b) ADDITIONAL CREDIT.—In addition to the credit allowed under subsection (a), a taxpayer may credit against the tax imposed by section 3301 for any taxable year an amount, with respect to the unemployment compensation law of each State certified as provided in section 3303 for the 12-month period ending on October 31 of such year, or with respect to any provisions thereof so certified, equal to the amount, if any, by which the contributions required to be paid by him with respect to the taxable year were less than the contributions such taxpayer would have been required to pay if throughout the taxable year he had been subject under such State law to the highest rate applied thereunder in such 12-month period to any person having individuals in his employ, or to a rate of 5.4%, whichever rate is lower.

(c) LIMIT ON TOTAL CREDITS.—

(1) The total credits allowed to a taxpayer under this section shall not exceed 90 percent of the tax against which such credits are allowable.

(2) If an advance or advances have been made to the unemployment account of a State under title XII of the Social Security Act, then the total credits (after applying subsections (a) and (b) and paragraph (1) of this subsection) otherwise allowable under this section for the taxable year in the case of a taxpayer subject to the unemployment compensation law of such State shall be reduced—

(A)(i) in the case of a taxable year beginning with the second consecutive January 1 as of the beginning of which there is a balance of such advances, by 5 percent of the tax imposed by section 3301 with respect to the wages paid by such taxpayer during such taxable year which are attributable to such State; and

(ii) in the case of any succeeding taxable year beginning with a consecutive January 1 as of the beginning of which there is a balance of such advances, by an additional 5 percent, for each such succeeding taxable year, of the tax imposed by section 3301 with respect to the wages paid by such taxpayer during such taxable year which are attributable to such State;

(B) in the case of a taxable year beginning with the third or fourth consecutive January 1 as of the beginning of which there is a balance of such advances, by the amount determined by multiplying the wages paid by such taxpayer during such taxable year which are attributable to such State by the percentage (if any), multiplied by a fraction, the numerator of which is the State's average annual wage in covered employment for the calendar year in which the determination is made and the denominator of which is the wage base under this chapter, by which—

(i) 2.7 percent multiplied by a fraction, the numerator of which is the wage base under this chapter and the denominator of which is the estimated United States average annual wage in covered employment for the calendar year in which the determination is to be made, exceeds

(ii) the average employer contribution rate for such State for the calendar year preceding such taxable year; and

(C) in the case of a taxable year beginning with the fifth or any succeeding consecutive January 1 as of the beginning of which there is a balance of such advances, by the amount determined by multiplying the wages paid by such taxpayer during such taxable year which are attributable to such State by the percentage (if any) by which—

(i) the 5-year benefit cost rate applicable to such State for such taxable year or (if higher) 2.7 percent, exceeds

(ii) the average employer contribution rate for such State for the calendar year preceding such taxable year.

The provisions of the preceding sentence shall not be applicable with respect to the taxable year beginning January 1, 1975, or any succeeding taxable year which begins before January 1, 1980; and, for purposes of such sentence, January 1, 1980, shall be deemed to be the first January 1 occurring after January 1, 1974, and consecutive taxable years in the period commencing January 1, 1980, shall be determined as if the taxable year which begins on January 1, 1980, were the taxable year immediately succeeding the taxable year which began on January 1, 1974. Subparagraph (C) shall not apply with respect to any taxable year to which it would otherwise apply (but subparagraph (B) shall apply to such taxable year) if the Secretary of Labor determines (on or before November 10 of such taxable year) that the State meets the requirements of subsection (f)(2)(B) for such taxable year.

(3) If the Secretary of Labor determines that a State, or State agency, has not—

(A) entered into the agreement described in section 239 of the Trade Act of 1974, with the Secretary of Labor before July 15, 1975, or

(B) fulfilled its commitments under an agreement with the Secretary of Labor as described in section 239 of the Trade Act of 1974,

then, in the case of a taxpayer subject to the unemployment compensation law of such State, the total credits (after applying subsections (a) and (b) and paragraphs (1) and (2) of this section) otherwise allowable under this section for a year during which such State or agency does not enter into or fulfill such an agreement shall be reduced by 7 1/2 percent of the tax imposed with respect to wages paid by such taxpayer during such year which are attributable to such State.

(d) DEFINITIONS AND SPECIAL RULES RELATING TO SUBSECTION (c).—

(1) RATE OF TAX DEEMED TO BE 6 percent[53].—In applying subsection (c), the tax imposed by section 3301 shall be computed at the rate of 6 percent in lieu of the rate provided by such section.

(2) WAGES ATTRIBUTABLE TO A PARTICULAR STATE.—For purposes of subsection (c), wages shall be attributable to a particular State if they are subject to the unemployment compensation law of the State, or (if not subject to the unemployment compensation law of any State) if they are determined (under rules or regulations prescribed by the Secretary) to be attributable to such State.

(3) ADDITIONAL TAXES INAPPLICABLE WHERE ADVANCES ARE REPAID BEFORE NOVEMBER 10 OF TAXABLE YEAR.—Paragraph (2) of subsection (c) shall not apply with respect to any State for the taxable year if (as of the beginning of November 10 of such year) there is no balance of advances referred to in such paragraph.

(4) AVERAGE EMPLOYER CONTRIBUTION RATE.—For purposes of subparagraphs (B) and (C) of subsection (c)(2), the average employer contribution rate for any State for any calendar year is that percentage obtained by dividing—

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[53] As in original.

(A) the total of the contributions paid into the State unemployment fund with respect to such calendar year, by

(B)(i) for purposes of subparagraph (B) of subsection (c)(2), the total of the wages (as determined without any limitation on amount) attributable to such State subject to contributions under this chapter with respect to such calendar year, and

(ii) for purposes of subparagraph (C) of subsection (c)(2), the total of the remuneration subject to contributions under the State unemployment compensation law with respect to such calendar year.

For purposes of subparagraph (C) of subsection (c)(2), if the average employer contribution rate for any State for any calendar year (determined without regard to this sentence) equals or exceeds 2.7 percent, such rate shall be determined by increasing the amount taken into account under subparagraph (A) of the preceding sentence by the aggregate amount of employee payments (if any) into the unemployment fund of such State with respect to such calendar year which are to be used solely in the payment of unemployment compensation.

(5) 5-YEAR BENEFIT COST RATE.—For purposes of subparagraph (C) of subsection (c)(2), the 5-year benefit cost rate applicable to any State for any taxable year is that percentage obtained by dividing—

(A) one-fifth of the total of the compensation paid under the State unemployment compensation law during the 5-year period ending at the close of the second calendar year preceding such taxable year, by

(B) the total of the remuneration subject to contributions under the State unemployment compensation law with respect to the first calendar year preceding such taxable year.

(6) ROUNDING.—If any percentage referred to in either subparagraph (B) or (C) of subsection (c)(2) is not a multiple of .1 percent, it shall be rounded to the nearest multiple of .1 percent.

(7) DETERMINATION AND CERTIFICATION OF PERCENTAGES.—The percentage referred to in subsection (c)(2)(B) or (C) for any taxable year for any State having a balance referred to therein shall be determined by the Secretary of Labor, and shall be certified by him to the Secretary of the Treasury before June 1 of such year, on the basis of a report furnished by such State to the Secretary of Labor before May 1 of such year. Any such State report shall be made as of the close of March 31 of the taxable year, and shall be made on such forms, and shall contain such information, as the Secretary of Labor deems necessary to the performance of his duties under this section.

(e) SUCCESSOR EMPLOYER.—Subject to the limits provided by subsection (c), if—

(1) an employer acquires during any calendar year substantially all the property used in the trade or business of another person, or used in a separate unit of a trade or business of such other person, and immediately after the acquisition employs in his trade or business one or more individuals who immediately prior to the acquisition were employed in the trade or business of such other person, and

(2) such other person is not an employer for the calendar year in which the acquisition takes place,

then, for the calendar year in which the acquisition takes place, in addition to the credits allowed under subsections (a) and (b), such employer may credit against the tax imposed by section 3301 for such year an amount equal to the credits which (without regard to subsection (c)) would have been allowable to such other person under subsections (a) and (b) and this subsection for such year, if such other person had been an employer, with respect to remuneration subject to contributions under the unemployment compensation law of a State paid by such other person to the individual or individuals described in paragraph (1).

(f) Limitation on Credit Reduction.—

(1) Limitation.—In the case of any State which meets the requirements of paragraph (2) with respect to any taxable year the reduction under subsection (c)(2) in credits otherwise applicable to taxpayers subject to the unemployment compensation law of such State shall not exceed the greater of—

(A) the reduction which was in effect with respect to such State under subsection (c)(2) for the preceding taxable year, or

(B) 0.6 percent of the wages paid by the taxpayer during such taxable year which are attributable to such State.

(2) Requirements.—The requirements of this paragraph are met by any State with respect to any taxable year if the Secretary of Labor determines (on or before November 10 of such taxable year) that—

(A) no State action was taken during the 12-month period ending on September 30 of such taxable year (excluding any action required under State law as in effect prior to the date of the enactment of this subsection) which has resulted or will result in a reduction in such State's unemployment tax effort (as defined by the Secretary of Labor in regulations),

(B) no State action was taken during the 12-month period ending on September 30 of such taxable year (excluding any action required under State law as in effect prior to the date of the enactment of this subsection) which has resulted or will result in a net decrease in the solvency of the State unemployment compensation system (as defined by the Secretary of Labor in regulations),

(C) the State unemployment tax rate for the taxable year equals or exceeds the average benefit cost ratio for calendar years in the 5-calendar year period ending with the last calendar year before the taxable year, and

(D) the outstanding balance for such State of advances under title XII of the Social Security Act on September 30 of such taxable year was not greater than the outstanding balance for such State of such advances on September 30 of the third preceding taxable year (or, for purposes of applying this subparagraph to taxable year 1983, September 30, 1981).

The requirements of subparagraphs (C) and (D) shall not apply to taxable years 1981 and 1982.

(3) Credit reductions for subsequent years.—If the credit reduction under subsection (c)(2) is limited by reason of para-

graph (1) of this subsection for any taxable year, for purposes of applying subsection (c)(2) to subsequent taxable years (including years after 1987), the taxable year for which the credit reduction was so limited (and January 1 thereof) shall not be taken into account.

(4) STATE UNEMPLOYMENT TAX RATE.—For purposes of this subsection—

(A) IN GENERAL.—The State unemployment tax rate for any taxable year is the percentage obtained by dividing—

(i) the total amount of contributions paid into the State unemployment fund with respect to such taxable year, by

(ii) the total amount of the remuneration subject to contributions under the State unemployment compensation law with respect to such taxable year (determined without regard to any limitation on the amount of wages subject to contribution under the State law).

(B) TREATMENT OF ADDITIONAL TAX UNDER THIS CHAPTER.—

(i) TAXABLE YEAR 1983.—In the case of taxable year 1983, any additional tax imposed under this chapter with respect to any State by reason of subsection (c)(2) shall be treated as contributions paid into the State unemployment fund with respect to such taxable year.

(ii) TAXABLE YEAR 1984.—In the case of taxable year 1984, any additional tax imposed under this chapter with respect to any State by reason of subsection (c)(2) shall (to the extent such additional tax is attributable to a credit reduction in excess of 0.6 of wages attributable to such State) be treated as contributions paid into the State unemployment fund with respect to such taxable year.

(5) BENEFIT COST RATIO.—For purposes of this subsection—

(A) IN GENERAL.—The benefit cost ratio for any calendar year is the percentage determined by dividing—

(i) the sum of the total of the compensation paid under the State unemployment compensation law during such calendar year and any interest paid during such calendar year on advances made to the State under title XII of the Social Security Act, by

(ii) the total amount of the remuneration subject to contributions under the State unemployment compensation law with respect to such calendar year (determined without regard to any limitation on the amount of remuneration subject to contribution under the State law).

(B) REIMBURSABLE BENEFITS NOT TAKEN INTO ACCOUNT.—For purposes of subparagraph (A), compensation shall not be taken into account to the extent—

(i) the State is entitled to reimbursement for such compensation under the provisions of any Federal law, or

(ii) such compensation is attributable to services performed for a reimbursing employer.

(C) Reimbursing employer.—The term "reimbursing employer" means any governmental entity or other organization (or group of governmental entities or any other organizations) which makes reimbursements in lieu of contributions to the State unemployment fund.

(D) Special rules for years before 1985.—

(i) Taxable year 1983.—For purposes of determining whether a State meets the requirements of paragraph (2)(C) for taxable year 1983, only regular compensation (as defined in section 205 of the Federal-State Extended Unemployment Compensation Act of 1970) shall be taken into account for purposes of determining the benefit ratio for any preceding calendar year before 1982.

(ii) Taxable year 1984.—For purposes of determining whether a State meets the requirements of paragraph (2)(C) for taxable year 1984, only regular compensation (as so defined) shall be taken into account for purposes of determining the benefit ratio for any preceding calendar year before 1981.

(E) Rounding.—If any percentage determined under subparagraph (A) is not a multiple of .1 percent, such percentage shall be reduced to the nearest multiple of .1 percent.

(6) Reports.—The Secretary of Labor may, by regulations, require a State to furnish such information at such time and in such manner as may be necessary for purposes of this subsection.

(7) Definitions and special rules.—The definitions and special rules set forth in subsection (d) shall apply to this subsection in the same manner as they apply to subsection (c).

(8) Partial limitation.—

(A) In the case of a State which would meet the requirements of this subsection for a taxable year prior to 1986 but for its failure to meet one of the requirements contained in subparagraph (C) or (D) of paragraph (2), the reduction under subsection (c)(2) in credits otherwise applicable to taxpayers in such State for such taxable year and each subsequent year (in a period of consecutive years for each of which a credit reduction is in effect for taxpayers in such State) shall be reduced by 0.1 percentage point.

(B) In the case of a State which does not meet the requirements of paragraph (2) but meets the requirements of subparagraphs (A) and (B) of paragraph (2) and which also meets the requirements of section 1202(b)(8)(B) of the Social Security Act with respect to such taxable year, the reduction under subsection (c)(2) in credits otherwise applicable to taxpayers in such State for such taxable year and each subsequent year (in a period of consecutive years for each of which a credit reduction is in effect for taxpayers in such State) shall be further reduced by an additional 0.1 percentage point.

(C) In no case shall the application of subparagraphs (A) and (B) reduce the credit reduction otherwise applicable under subsection (c)(2) below the limitation under paragraph

(1).

(g) CREDIT REDUCTION NOT TO APPLY WHEN STATE MAKES CERTAIN REPAYMENTS.—

(1) IN GENERAL.—In the case of any State which meets requirements of paragraph (2) with respect to any taxable year, subsection (c)(2) shall not apply to such taxable year; except that such taxable year (and January 1 of such taxable year) shall (except as provided in subsection (f)(3)) be taken into account for purposes of applying subsection (c)(2) to succeeding taxable years.

(2) REQUIREMENTS.—The requirements of this paragraph are met by any State with respect to any taxable year if the Secretary of Labor determines that—

(A) the repayments during the 1-year period ending on November 9 of such taxable year made by such State of advances under title XII of the Social Security Act are not less than the sum of—

(i) the potential additional taxes for such taxable year, and

(ii) any advances made to such State during such 1-year period under such title XII,

(B) there will be sufficient amounts in the State unemployment fund to pay all compensation during the 3-month period beginning on November 1 of such taxable year without receiving any advance under title XII of the Social Security Act, and

(C) there is a net increase in the solvency of the State unemployment compensation system for the taxable year attributable to changes made in the State law after the date on which the first advance taken into account in determining the amount of the potential additional taxes was made (or, if later, after the date of the enactment of this subsection) and such net increase equals or exceeds the potential additional taxes for such taxable year.

(3) DEFINITIONS.—For purposes of paragraph (2)—

(A) POTENTIAL ADDITIONAL TAXES.—The term "potential additional taxes" means, with respect to any State for any taxable year, the aggregate amount of the additional tax which would be payable under this chapter for such taxable year by all taxpayers subject to the unemployment compensation law of such State for such taxable year if paragraph (2) of subsection (c) had applied to such taxable year and any preceding taxable year without regard to this subsection but with regard to subsection (f).

(B) TREATMENT OF CERTAIN REDUCTIONS.—Any reduction in the State's balance under section 901(d)(1) of the Social Security Act shall not be treated as a repayment made by such State.

(4) REPORTS.—The Secretary of Labor may require a State to furnish such information at such time and in such manner as may be necessary for purposes of paragraph (2).

SEC. 3303. CONDITIONS OF ADDITIONAL CREDIT ALLOWANCE.

(a) STATE STANDARDS.—A taxpayer shall be allowed an additional credit under section 3302(b) with respect to any reduced rate of contributions permitted by a State law, only if the Secretary of Labor finds that under such law—

(1) no reduced rate of contributions to a pooled fund or to a partially pooled account is permitted to a person (or group of persons) having individuals in his (or their) employ except on the basis of his (or their) experience with respect to unemployment or other factors bearing a direct relation to unemployment risk during not less than the 3 consecutive years immediately preceding the computation date;

(2) no reduced rate of contributions to a guaranteed employment account is permitted to a person (or a group of persons) having individuals in his (or their) employ unless—

(A) the guaranty of remuneration was fulfilled in the year preceding the computation date; and

(B) the balance of such account amounts to not less than 2 1/2 percent of that part of the payroll or payrolls for the 3 years preceding the computation date by which contributions to such account were measured; and

(C) such contributions were payable to such account with respect to 3 years preceding the computation date;

(3) no reduced rate of contributions to a reserve account is permitted to a person (or group of persons) having individuals in his (or their) employ unless—

(A) compensation has been payable from such account throughout the year preceding the computation date, and

(B) the balance of such account amounts to not less than five times the largest amount of compensation paid from such account within any 1 of the 3 years preceding such date, and

(C) the balance of such account amounts to not less than 2 1/2 percent of that part of the payroll or payrolls for the 3 years preceding such date by which contributions to such account were measured, and

(D) such contributions were payable to such account with respect to the 3 years preceding the computation date.

For any person (or group of persons) who has (or have) not been subject to the State law for a period of time sufficient to compute the reduced rates permitted by paragraphs (1), (2), and (3) of this subsection on a 3-year basis (i) the period of time required may be reduced to the amount of time the person (or group of persons) has (or have) had experience under or has (or have) been subject to the State law, whichever is appropriate, but in no case less than 1 year immediately preceding the computation date, or (ii) a reduced rate (not less than 1 percent) may be permitted by the State law on a reasonable basis other than as permitted by paragraph (1), (2), or (3).

(b) CERTIFICATION BY THE SECRETARY OF LABOR WITH RESPECT TO ADDITIONAL CREDIT ALLOWANCE.—

(1) On October 31 of each calendar year, the Secretary of Labor shall certify to the Secretary of the Treasury the law of each State (certified by the Secretary of Labor as provided in section 3304 for the 12-month period ending on such October 31), with respect to which he finds that reduced rates of contributions

were allowable with respect to such 12-month period only in accordance with the provisions of subsection (a).

(2) If the Secretary of Labor finds that under the law of a single State (certified by the Secretary of Labor as provided in section 3304) more than one type of fund or account is maintained, and reduced rates of contributions to more than one type of fund or account were allowable with respect to any 12-month period ending on October 31, and one or more of such reduced rates were allowable under conditions not fulfilling the requirements of subsection (a), the Secretary of Labor shall, on such October 31, certify to the Secretary of the Treasury only those provisions of the State law pursuant to which reduced rates of contributions were allowable with respect to such 12-month period under conditions fulfilling the requirements of subsection (a), and shall, in connection therewith, designate the kind of fund or account, as defined in subsection (c), established by the provisions so certified. If the Secretary of Labor finds that a part of any reduced rate of contributions payable under such law or under such provisions is required to be paid into one fund or account and a part into another fund or account, the Secretary of Labor shall make such certification pursuant to this paragraph as he finds will assure the allowance of additional credits only with respect to that part of the reduced rate of contributions which is allowed under provisions which do fulfill the requirements of subsection (a).

(3) The Secretary of Labor shall, within 30 days after any State law is submitted to him for such purpose, certify to the State agency his findings with respect to reduced rates of contributions to a type of fund or account, as defined in subsection (c), which are allowable under such State law only in accordance with the provisions of subsection (a). After making such findings, the Secretary of Labor shall not withhold his certification to the Secretary of the Treasury of such State law, or of the provisions thereof with respect to which such findings were made, for any 12-month period ending on October 31 pursuant to paragraph (1) or (2) unless, after reasonable notice and opportunity for hearing to the State agency, the Secretary of Labor finds the State law no longer contains the provisions specified in subsection (a) or the State has, with respect to such 12-month period, failed to comply substantially with any such provision.

(c) DEFINITIONS.—As used in this section—

(1) RESERVE ACCOUNT.—The term "reserve account" means a separate account in an unemployment fund, maintained with respect to a person (or group of persons) having individuals in his (or their) employ, from which account, unless such account is exhausted, is paid all and only compensation payable on the basis of services performed for such person (or for one or more of the persons comprising the group).

(2) POOLED FUND.—The term "pooled fund" means an unemployment fund or any part thereof (other than a reserve account or a guaranteed employment account) into which the total contributions of persons contributing thereto are payable, in which all contributions are mingled and undivided, and from which compensation is payable to all individuals eligible for compensation from such fund.

(3) **Partially pooled account.**—The term "partially pooled account" means a part of an unemployment fund in which part of the fund all contributions thereto are mingled and undivided, and from which part of the fund compensation is payable only to individuals to whom compensation would be payable from a reserve account or from a guaranteed employment account but for the exhaustion or termination of such reserve account or of such guaranteed employment account. Payments from a reserve account or guaranteed employment account into a partially pooled account shall not be construed to be inconsistent with the provisions of paragraph (1) or (4).

(4) **Guaranteed employment account.**—The term "guaranteed employment account" means a separate account, in an unemployment fund, maintained with respect to a person (or group of persons) having individuals in his (or their) employ who, in accordance with the provisions of the State law or of a plan thereunder approved by the State agency,

(A) guarantees in advance at least 30 hours of work, for which remuneration will be paid at not less than stated rates, for each of 40 weeks (or if more, 1 weekly hour may be deducted for each added week guaranteed) in a year, to all the individuals who are in his (or their) employ in, and who continue to be available for suitable work in, one or more distinct establishments, except that any such individual's guaranty may commence after a probationary period (included within the 11 or less consecutive weeks immediately following the first week in which the individual renders services), and

(B) gives security or assurance, satisfactory to the State agency, for the fulfillment of such guaranties, from which account, unless such account is exhausted or terminated, is paid all and only compensation, payable on the basis of services performed for such person (or for one or more of the persons comprising the group), to any such individual whose guaranteed remuneration has not been paid (either pursuant to the guaranty or from the security or assurance provided for the fulfillment of the guaranty), or whose guaranty is not renewed and who is otherwise eligible for compensation under the State law.

(5) **Year.**—The term "year" means any 12 consecutive calendar months.

(6) **Balance.**—The term "balance", with respect to a reserve account or a guaranteed employment account, means the amount standing to the credit of the account as of the computation date; except that, if subsequent to January 1, 1940, any moneys have been paid into or credited to such account other than payments thereto by persons having individuals in their employ, such term shall mean the amount in such account as of the computation date less the total of such other moneys paid into or credited to such account subsequent to January 1, 1940.

(7) **Computation date.**—The term "computation date" means the date, occurring at least once in each calendar year and within 27 weeks prior to the effective date of new rates of contributions, as of which such rates are computed.

(8) REDUCED RATE.—The term "reduced rate" means a rate of contributions lower than the standard rate applicable under the State law, and the term "standard rate" means the rate on the basis of which variations therefrom are computed.

(d) VOLUNTARY CONTRIBUTIONS.—A State law may, without being deemed to violate the standards set forth in subsection (a), permit voluntary contributions to be used in the computation of reduced rates if such contributions are paid prior to the expiration of 120 days after the beginning of the year for which such rates are effective.

(e) PAYMENTS BY CERTAIN NONPROFIT ORGANIZATIONS.—A State may, without being deemed to violate the standards set forth in subsection (a), permit an organization (or a group of organizations) described in section 501(c)(3) which is exempt from income tax under section 501(a) to elect (in lieu of paying contributions) to pay into the State unemployment fund amounts equal to the amounts of compensation attributable under the State law to service performed in the employ of such organization (or group).

(f) TRANSITION.—To facilitate the orderly transition to coverage of service to which section 3309(a)(1)(A) applies, a State law may provide that an organization (or group of organizations) which elects before April 1, 1972, to make payments (in lieu of contributions) into the State unemployment fund as provided in section 3309(a)(2), and which had paid contributions into such fund under the State law with respect to such service performed in its employ before January 1, 1969, is not required to make any such payment (in lieu of contributions) on account of compensation paid after its election as heretofore described which is attributable under the State law to service performed in its employ, until the total of such compensation equals the amount—

(1) by which the contributions paid by such organization (or group) with respect to a period before the election provided by section 3309(a)(2), exceed

(2) the unemployment compensation for the same period which was charged to the experience-rating account of such organization (or group) or paid under the State law on the basis of wages paid by it or service performed in its employ, whichever is appropriate.

(g) TRANSITIONAL RULE FOR UNEMPLOYMENT COMPENSATION AMENDMENTS OF 1976.—To facilitate the orderly transition to coverage of service to which section 3309(a)(1)(A) applies by reason of the enactment of the Unemployment Compensation Amendments of 1976, a State law may provide that an organization (or group of organizations) which elects, when such election first becomes available under the State law with respect to such service, to make payments (in lieu of contributions) into the State unemployment fund as provided in section 3309(a)(2), and which had paid contributions into such fund under the State law with respect to such service performed in its employ before the date of the enactment of this subsection, is not required to make any such payment (in lieu of contributions) on account of compensation paid after its election as heretofore described which is attributable under the State law to such service performed in its employ, until the total of such compensation equals the amount—

(1) by which the contributions paid by such organization (or group) on the basis of wages for such service with respect to a period before the election provided by section 3309(a)(2), exceed

(2) the unemployment compensation for the same period which was charged to the experience-rating account of such organization (or group) or paid under the State law on the basis of such service performed in its employ or wages paid for such service, whichever is appropriate.

SEC. 3304. APPROVAL OF STATE LAWS.

(a) REQUIREMENTS.—The Secretary of Labor shall approve any State law submitted to him, within 30 days of such submission, which he finds provides that—

(1) all compensation is to be paid through public employment offices or such other agencies as the Secretary of Labor may approve;

(2) no compensation shall be payable with respect to any day of unemployment occurring within 2 years after the first day of the first period with respect to which contributions are required;

(3) all money received in the unemployment fund shall (except for refunds of sums erroneously paid into such fund and except for refunds paid in accordance with the provisions of section 3305(b)) immediately upon such receipt be paid over to the Secretary of the Treasury to the credit of the Unemployment Trust Fund established by section 904 of the Social Security Act (42 U.S.C. 1104);

(4) all money withdrawn from the unemployment fund of the State shall be used solely in the payment of unemployment compensation, exclusive of expenses of administration, and for refunds of sums erroneously paid into such fund and refunds paid in accordance with the provisions of section 3305(b); except that—

(A) an amount equal to the amount of employee payments into the unemployment fund of a State may be used in the payment of cash benefits to individuals with respect to their disability, exclusive of expenses of administration;

(B) the amounts specified by section 903(c)(2) of the Social Security Act may, subject to the conditions prescribed in such section, be used for expenses incurred by the State for administration of its unemployment compensation law and public employment offices;

(C) nothing in this paragraph shall be construed to prohibit deducting an amount from unemployment compensation otherwise payable to an individual and using the amount so deducted to pay for health insurance if the individual elected to have such deduction made and such deduction was made under a program approved by the Secretary of Labor; and

(D) amounts may be deducted from unemployment benefits and used to repay overpayments as provided in section 303(g) of the Social Security Act;

(5) compensation shall not be denied in such State to any otherwise eligible individual for refusing to accept new work under any of the following conditions:

(A) if the position offered is vacant due directly to a strike, lockout, or other labor dispute;

(B) if the wages, hours, or other conditions of the work offered are substantially less favorable to the individual than those prevailing for similar work in the locality;

(C) if as a condition of being employed the individual would be required to join a company union or to resign from or refrain from joining any bona fide labor organization;

(6)(A) compensation is payable on the basis of service to which section 3309(a)(1) applies, in the same amount, on the same terms, and subject to the same conditions as compensation payable on the basis of other service subject to such law; except that—

(i) with respect to services in an instructional, research, or principal administrative capacity for an educational institution to which section 3309(a)(1) applies, compensation shall not be payable based on such services for any week commencing during the period between two successive academic years or terms (or, when an agreement provides instead for a similar period between two regular but not successive terms, during such period) to any individual if such individual performs such services in the first of such academic years (or terms) and if there is a contract or reasonable assurance that such individual will perform services in any such capacity for any educational institution in the second of such academic years or terms,

(ii) with respect to services in any other capacity for an educational institution to which section 3309(a)(1) applies—

(I) compensation payable on the basis of such services shall be denied to any individual for any week which commences during a period between 2 successive academic years or terms if such individual performs such services in the first of such academic years or terms and there is a reasonable assurance that such individual will perform such services in the second of such academic years or terms, except that

(II) if compensation is denied to any individual for any week under subclause (I) and such individual was not offered an opportunity to perform such services for the educational institution for the second of such academic years or terms, such individual shall be entitled to a retroactive payment of the compensation for each week for which the individual filed a timely claim for compensation and for which compensation was denied solely by reason of subclause (I),

(iii) with respect to any services described in clause (i) or (ii), compensation payable on the basis of such services shall be denied to any individual for any week which commences during an established and customary vacation period or holiday recess if such individual performs such services in the period immediately before such vacation period or holiday recess, and there is a reasonable assurance that such individual will perform such services in the period immediately following such vacation period or holiday recess,

(iv) with respect to any services described in clause (i) or (ii), compensation payable on the basis of services in any such capacity shall be denied as specified in clauses (i), (ii), and (iii) to any individual who performed such services in an educational institution while in the employ of an educational service agency, and for this purpose the term "educational service agency" means a governmental agency or governmental entity which is established and operated exclusively for the purpose of providing such services to one or more educational institutions, and

(v) with respect to services to which section 3309(a)(1) applies, if such services are provided to or on behalf of an educational institution, compensation may be denied under the same circumstances as described in clauses (i) through (iv), and

(B) payments (in lieu of contributions) with respect to service to which section 3309(a)(1) applies may be made into the State unemployment fund on the basis set forth in section 3309(a)(2);

(7) an individual who has received compensation during his benefit year is required to have had work since the beginning of such year in order to qualify for compensation in his next benefit year;

(8) compensation shall not be denied to an individual for any week because he is in training with the approval of the State agency (or because of the application, to any such week in training, of State law provisions relating to availability for work, active search for work, or refusal to accept work);

(9)(A) compensation shall not be denied or reduced to an individual solely because he files a claim in another State (or a contiguous country with which the United States has an agreement with respect to unemployment compensation) or because he resides in another State (or such a contiguous country) at the time he files a claim for unemployment compensation;

(B) the State shall participate in any arrangements for the payment of compensation on the basis of combining an individual's wages and employment covered under the State law with his wages and employment covered under the unemployment compensation law of other States which are approved by the Secretary of Labor in consultation with the State unemployment compensation agencies as reasonably calculated to assure the prompt and full payment of compensation in such situations. Any such arrangement shall include provisions for (i) applying the base period of a single State law to a claim involving the combining of an individual's wages and employment covered under two or more State laws, and (ii) avoiding duplicate use of wages and employment by reason of such combining;

(10) compensation shall not be denied to any individual by reason of cancellation of wage credits or total reduction of his benefit rights for any cause other than discharge for misconduct connected with his work, fraud in connection with a claim for compensation, or receipt of disqualifying income;

(11) extended compensation shall be payable as provided by the Federal-State Extended Unemployment Compensation Act of 1970;

(12) no person shall be denied compensation under such State law solely on the basis of pregnancy or termination of pregnancy;

(13) compensation shall not be payable to any individual on the basis of any services, substantially all of which consist of participating in sports or athletic events or training or preparing to so participate, for any week which commences during the period between two successive sport seasons (or similar periods) if such individual performed such services in the first of such seasons (or similar periods) and there is a reasonable assurance that such individual will perform such services in the later of such seasons (or similar periods);

(14)(A) compensation shall not be payable on the basis of services performed by an alien unless such alien is an individual who was lawfully admitted for permanent residence at the time such services were performed, was lawfully present for purposes of performing such services, or was permanently residing in the United States under color of law at the time such services were performed (including an alien who was lawfully present in the United States as a result of the application of the provisions of [54] section 212(d)(5) of the Immigration and Nationality Act),

(B) any data or information required of individuals applying for compensation to determine whether compensation is not payable to them because of their alien status shall be uniformly required from all applicants for compensation, and

(C) in the case of an individual whose application for compensation would otherwise be approved, no determination by the State agency that compensation to such individual is not payable because of his alien status shall be made except upon a preponderance of the evidence;

(15) the amount of compensation payable to an individual for any week which begins after March 31, 1980, and which begins in a period with respect to which such individual is receiving a governmental or other pension, retirement or retired pay, annuity, or any other similar periodic payment which is based on the previous work of such individual shall be reduced (but not below zero) by an amount equal to the amount of such pension, retirement or retired pay, annuity, or other payment, which is reasonably attributable to such week except that—

(A) the requirements of this paragraph shall apply to any pension, retirement or retired pay, annuity, or other similar periodic payment only if—

(i) such pension, retirement or retired pay, annuity, or similar payment is under a plan maintained (or contributed to) by a base period employer or chargeable employer (as determined under applicable law), and

(ii) in the case of such a payment not made under the Social Security Act or the Railroad Retirement Act of 1974 (or the corresponding provisions of prior law), services performed for such employer by the individual after the beginning of the base period (or remuneration for such services) affect eligibility for, or increase the amount of, such pension, retirement or retired pay, annuity, or similar payment, and

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[54] P.L. 101-649, §162(e)(4), struck out "section 203(a)(7) or".

(B) the State law may provide for limitations on the amount of any such a reduction to take into account contributions made by the individual for the pension, retirement or retired pay, annuity, or other similar periodic payment;

(16)(A) wage information contained in the records of the agency administering the State law which is necessary (as determined by the Secretary of Health, Education, and Welfare in regulations) for purposes of determining an individual's eligibility for aid or services, or the amount of such aid or services, under a State plan for aid and services to needy families with children approved under part A of title IV of the Social Security Act, shall be made available to a State or political subdivision thereof when such information is specifically requested by such State or political subdivision for such purposes, and

(B) such safeguards are established as are necessary (as determined by the Secretary of Health, Education, and Welfare in regulations) to insure that such information is used only for the purposes authorized under subparagraph (A);

(17) any interest required to be paid on advances under title XII of the Social Security Act shall be paid in a timely manner and shall not be paid, directly or indirectly (by an equivalent reduction in State unemployment taxes or otherwise) by such State from amounts in such State's unemployment fund; and

(18) all the rights, privileges, or immunities conferred by such law or by acts done pursuant thereto shall exist subject to the power of the legislature to amend or repeal such law at any time.

(b) NOTIFICATION.—The Secretary of Labor shall, upon approving such law, notify the governor of the State of his approval.

(c) CERTIFICATION.—On October 31 of each taxable year the Secretary of Labor shall certify to the Secretary of the Treasury each State whose law he has previously approved, except that he shall not certify any State which, after reasonable notice and opportunity for hearing to the State agency, the Secretary of Labor finds has amended its law so that it no longer contains the provisions specified in subsection (a) or has with respect to the 12-month period ending on such October 31 failed to comply substantially with any such provision in such subsection. No finding of a failure to comply substantially with any provision in paragraph (5) of subsection (a) shall be based on an application or interpretation of State law (1) until all administrative review provided for under the laws of the State has been exhausted, or (2) with respect to which the time for judicial review provided by the laws of the State has not expired, or (3) with respect to which any judicial review is pending. On October 31 of any taxable year, the Secretary of Labor shall not certify any State which, after reasonable notice and opportunity for hearing to the State agency, the Secretary of Labor finds has failed to amend its law so that it contains each of the provisions required by law to be included therein (including provisions relating to the Federal-State Extended Unemployment Compensation Act of 1970 (or any amendments thereto) as required under subsection (a)(11)), or has, with respect to the twelve-month period ending on such October 31, failed to comply substantially with any such provision.

(d) NOTICE OF NONCERTIFICATION.—If at any time the Secretary of Labor has reason to believe that a State whose law he has previously approved may not be certified under subsection (c), he shall promptly so notify the governor of such State.

(e) CHANGE OF LAW DURING 12-MONTH PERIOD.—Whenever—

(1) any provision of this section, section 3302, or section 3303 refers to a 12-month period ending on October 31 of a year, and

(2) the law applicable to one portion of such period differs from the law applicable to another portion of such period,

then such provision shall be applied by taking into account for each such portion the law applicable to such portion.

(f) DEFINITION OF INSTITUTION OF HIGHER EDUCATION.—For purposes of subsection (a)(6), the term "institution of higher education" means an educational institution in any State which—

(1) admits as regular students only individuals having a certificate of graduation from a high school, or the recognized equivalent of such a certificate;

(2) is legally authorized within such State to provide a program of education beyond high school;

(3) provides an educational program for it which awards a bachelor's or higher degree, or provides a program which is acceptable for full credit toward such a degree, or offers a program of training to prepare students for gainful employment in a recognized occupation; and

(4) is a public or other nonprofit institution.

SEC. 3305. APPLICABILITY OF STATE LAW.

(a) INTERSTATE AND FOREIGN COMMERCE.—No person required under a State law to make payments to an unemployment fund shall be relieved from compliance therewith on the ground that he is engaged in interstate or foreign commerce, or that the State law does not distinguish between employees engaged in interstate or foreign commerce and those engaged in intrastate commerce.

(b) FEDERAL INSTRUMENTALITIES IN GENERAL.—The legislature of any State may require any instrumentality of the United States (other than an instrumentality to which section 3306(c)(6) applies), and the individuals in its employ, to make contributions to an unemployment fund under a State unemployment compensation law approved by the Secretary of Labor under section 3304 and (except as provided in section 5240 of the Revised Statutes, as amended (12 U.S.C., sec. 484), and as modified by subsection (c)), to comply otherwise with such law. The permission granted in this subsection shall apply (A) only to the extent that no discrimination is made against such instrumentality, so that if the rate of contribution is uniform upon all other persons subject to such law on account of having individuals in their employ, and upon all employees of such persons, respectively, the contributions required of such instrumentality or the individuals in its employ shall not be at a greater rate than is required of such other persons and such employees, and if the rates are determined separately for different persons or classes of persons having individuals in their employ or for different classes of employees, the determination shall be based solely upon unemployment experience and other factors bearing a direct relation to unemployment risk; (B) only if such State law makes provision for the refund of any contributions required under such law from an instrumentality of the United States or its employees for any year in the event such State is not certified by the Secretary of Labor under section 3304 with respect to such year; and (C) only if such State law makes provision for the payment of unemployment compensation to any employee of any such instrumentality of the United States in the same amount, on the same terms, and subject to the same conditions as unemployment compensation is payable to employees of other employers under the State unemployment compensation law.

(c) NATIONAL BANKS.—Nothing contained in section 5240 of the Revised Statutes, as amended (12 U.S.C. 484), shall prevent any State from requiring any national banking association to render returns and reports relative to the association's employees, their remuneration and services, to the same extent that other persons are required to render like returns and reports under a State law requiring contributions to an unemployment fund. The Comptroller of the Currency shall, upon receipt of a copy of any such return or report of a national banking association from, and upon request of, any duly authorized official, body, or commission of a State, cause an examination of the correctness of such return or report to be made at the time of the next succeeding examination of such association, and shall thereupon transmit to such official, body, or commission a complete statement of his findings respecting the accuracy of such returns or reports.

(d) FEDERAL PROPERTY.—No person shall be relieved from compliance with a State unemployment compensation law on the ground that services were performed on land or premises owned, held, or possessed by the United States, and any State shall have full jurisdiction and power to enforce the provisions of such law to the same extent and with the same effect as though such place were not owned, held, or possessed by the United States.

⟦(e) Repealed.[55]⟧

(f) AMERICAN VESSELS.—The legislature of any State in which a person maintains the operating office, from which the operations of an American vessel operating on navigable waters within or within and without the United States are ordinarily and regularly supervised, managed, directed and controlled, may require such person and the officers and members of the crew of such vessel to make contributions to its unemployment fund under its State unemployment compensation law approved by the Secretary of Labor under section 3304 and otherwise to comply with its unemployment compensation law with respect to the service performed by an officer or member of the crew on or in connection with such vessel to the same extent and with the same effect as though such service was performed entirely within such State. Such person and the officers and members of the crew of such vessel shall not be required to make contributions, with respect to such service, to the unemployment fund of any other State. The permission granted by this subsection is subject to the condition that such service shall be treated, for purposes of wage credits given employees, like other service subject to such State unemployment compensation law performed for such person in such State, and also subject to the same limitation, with respect to contributions required from such person and from the officers and members of the crew of such vessel, as is imposed by the second sentence (other than clause (B) thereof) of subsection (b) with respect to contributions required from instrumentalities of the United States and from individuals in their employ.

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[55] P.L. 83-767, §4(c); 68 Stat. 1135.

(g) VESSELS OPERATED BY GENERAL AGENTS OF UNITED STATES.—The permission granted by subsection (f) shall apply in the same manner and under the same conditions (including the obligation to comply with all requirements of State unemployment compensation laws) to general agents of the Secretary of Commerce with respect to service performed by officers and members of the crew on or in connection with American vessels—

(1) owned by or bareboat chartered to the United States, and

(2) whose business is conducted by such general agents.

As to any such vessel, the State permitted to require contributions on account of such service shall be the State to which the general agent would make contributions if the vessel were operated for his own account. Such general agents are designated, for this purpose, instrumentalities of the United States neither wholly nor partially owned by it and shall not be exempt from the tax imposed by section 3301. The permission granted by this subsection is subject to the same conditions and limitations as are imposed in subsection (f), except that clause (B) of the second sentence of subsection (b) shall apply.

(h) REQUIREMENT BY STATE OF CONTRIBUTIONS.—Any State may, as to service performed on account of which contributions are made pursuant to subsection (g)—

(1) require contributions from persons performing such service under its unemployment compensation law or temporary disability insurance law administered in connection therewith, and

(2) require general agents of the Secretary of Commerce to make contributions under such temporary disability insurance law and to make such deductions from wages or remuneration as are required by such unemployment compensation or temporary disability insurance law.

(i) GENERAL AGENT AS LEGAL ENTITY.—Each general agent of the Secretary of Commerce making contributions pursuant to subsection (g) or (h) shall, for purposes of such subsections, be considered a legal entity in his capacity as an instrumentality of the United States, separate and distinct from his identity as a person employing individuals on his own account.

(j) DENIAL OF CREDITS IN CERTAIN CASES.—Any person required, pursuant to the permission granted by this section, to make contributions to an unemployment fund under a State unemployment compensation law approved by the Secretary of Labor under section 3304 shall not be entitled to the credits permitted, with respect to the unemployment compensation law of a State, by subsections (a) and (b) of section 3302 against the tax imposed by section 3301 for any taxable year if, on October 31 of such taxable year, the Secretary of Labor certifies to the Secretary of the Treasury his finding, after reasonable notice and opportunity for hearing to the State agency, that the unemployment compensation law of such State is inconsistent with any one or more of the conditions on the basis of which such permission is granted or that, in the application of the State law with respect to the 12-month period ending on such October 31, there has been a substantial failure to comply with any one or more of such conditions. For purposes of section 3310, a finding of the Secretary of Labor under this subsection shall be treated as a finding under section 3304(c).

SEC. 3306. DEFINITIONS.

(a) EMPLOYER.—For purposes of this chapter—

(1) IN GENERAL.—The term "employer" means, with respect to any calendar year, any person who—

(A) during any calendar quarter in the calendar year or the preceding calendar year paid wages of $1,500 or more, or

(B) on each of some 20 days during the calendar year or during the preceding calendar year, each day being in a different calendar week, employed at least one individual in employment for some portion of the day.

For purposes of this paragraph, there shall not be taken into account any wages paid to, or employment of, an employee performing domestic services referred to in paragraph (3).

(2) AGRICULTURAL LABOR.—In the case of agricultural labor, the term "employer" means, with respect to any calendar year, any person who—

(A) during any calendar quarter in the calendar year or the preceding calendar year paid wages of $20,000 or more for agricultural labor, or

(B) on each of some 20 days during the calendar year or during the preceding calendar year, each day being in a different calendar week, employed at least 10 individuals in employment in agricultural labor for some portion of the day.

(3) DOMESTIC SERVICE.—In the case of domestic service in a private home, local college club, or local chapter of a college fraternity or sorority, the term "employer" means, with respect to any calendar year, any person who during any calendar quarter in the calendar year or the preceding calendar year paid wages in cash of $1,000 or more for such service.

(4) SPECIAL RULE.—A person treated as an employer under paragraph (3) shall not be treated as an employer with respect to wages paid for any service other than domestic service referred to in paragraph (3) unless such person is treated as an employer under paragraph (1) or (2) with respect to such other service.

(b) WAGES.—For purposes of this chapter, the term "wages" means all remuneration for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash; except that such term shall not include—

(1) that part of the remuneration which, after remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) equal to $7,000 with respect to employment has been paid to an individual by an employer during any calendar year, is paid to such individual by such employer during such calendar year. If an employer (hereinafter referred to as successor employer) during any calendar year acquires substantially all the property used in a trade or business of another employer (hereinafter referred to as a predecessor), or

used in a separate unit of a trade or business of a predecessor, and immediately after the acquisition employs in his trade or business an individual who immediately prior to the acquisition was employed in the trade or business of such predecessor, then, for the purpose of determining whether the successor employer has paid remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment equal to $7,000 to such individual during such calendar year, any remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment paid (or considered under this paragraph as having been paid) to such individual by such predecessor during such calendar year and prior to such acquisition shall be considered as having been paid by such successor employer;

(2) the amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of his dependents under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally and their dependents) or for a class or classes of his employees (or for a class or classes of his employees and their dependents), on account of—

(A) sickness or accident disability (but, in the case of payments made to an employee or any of his dependents, this subparagraph shall exclude from the term "wages" only payments which are received under a workmen's compensation law), or

(B) medical or hospitalization expenses in connection with sickness or accident disability, or

(C) death;

[(3) Stricken.[56]]

(4) any payment on account of sickness or accident disability, or medical or hospitalization expenses in connection with sickness or accident disability, made by an employer to, or on behalf of, an employee after the expiration of 6 calendar months following the last calendar month in which the employee worked for such employer;

(5) any payment made to, or on behalf of, an employee or his beneficiary—

(A) from or to a trust described in section 401(a) which is exempt from tax under section 501(a) at the time of such payment unless such payment is made to an employee of the trust as remuneration for services rendered as such employee and not as a beneficiary of the trust, or

(B) under or to an annuity plan which, at the time of such payment, is a plan described in section 403(a),

(C) under a simplified employee pension (as defined in section 408(k)(1)), other than any contributions described in section 408(k)(6),

(D) under or to an annuity contract described in section 403(b), other than a payment for the purchase of such contract which is made by reason of a salary reduction agreement (whether evidenced by a written instrument or otherwise),

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[56] P.L. 98-21, §324(b)(3)(B); 97 Stat. 124.

(E) under or to an exempt governmental deferred compensation plan (as defined in section 3121(v)(3)),

(F) to supplement pension benefits under a plan or trust described in any of the foregoing provisions of this paragraph to take into account some portion or all of the increase in the cost of living (as determined by the Secretary of Labor) since retirement but only if such supplemental payments are under a plan which is treated as a welfare plan under section 3(2)(B)(ii) of the Employee Retirement Income Security Act of 1974; or

(G) under a cafeteria plan (within the meaning of section 125) if such payment would not be treated as wages without regard to such plan and it is reasonable to believe that (if section 125 applied for purposes of this section) section 125 would not treat any wages as constructively received,

(6) the payment by an employer (without deduction from the remuneration of the employee)—

(A) of the tax imposed upon an employee under section 3101, or

(B) of any payment required from an employee under a State unemployment compensation law,

with respect to remuneration paid to an employee for domestic service in a private home of the employer or for agricultural labor;

(7) remuneration paid in any medium other than cash to an employee for service not in the course of the employer's trade or business;

[(8) Stricken.[57]**]**

(9) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of the payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 217 (determined without regard to section 274(n));

(10) any payment or series of payments by an employer to an employee or any of his dependents which is paid—

(A) upon or after the termination of an employee's employment relationship because of (i) death, or (ii) retirement for disability, and

(B) under a plan established by the employer which makes provision for his employees generally or a class or classes of his employees (or for such employees or class or classes of employees and their dependents),

other than any such payment or series of payments which would have been paid if the employee's employment relationship had not been so terminated;

(11) remuneration for agricultural labor paid in any medium other than cash;

(12) any contribution, payment, or service, provided by an employer which may be excluded from the gross income of an employee, his spouse, or his dependents, under the provisions of

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[57] P.L. 98-21, §324(b)(3)(B); 97 Stat. 124.

section 120 (relating to amounts received under qualified group legal services plans);

(13) any payment made, or benefit furnished, to or for the benefit of an employee if at the time of such payment or such furnishing it is reasonable to believe that the employee will be able to exclude such payment or benefit from income under section 127 or 129;

(14) the value of any meals or lodging furnished by or on behalf of the employer if at the time of such furnishing it is reasonable to believe that the employee will be able to exclude such items from income under section 119;

(15) any payment made by an employer to a survivor or the estate of a former employee after the calendar year in which such employee died; or

(16) any benefit provided to or on behalf of an employee if at the time such benefit is provided it is reasonable to believe that the employee will be able to exclude such benefit from income under section 74(c), 117, or 132.

Except as otherwise provided in regulations prescribed by the Secretary, any third party which makes a payment included in wages solely by reason of the parenthetical matter contained in subparagraph (A) of paragraph (2) shall be treated for purposes of this chapter and chapter 22 as the employer with respect to such wages. Nothing in the regulations prescribed for purposes of chapter 24 (relating to income tax withholding) which provides an exclusion from "wages" as used in such chapter shall be construed to require a similar exclusion from "wages" in the regulations prescribed for purposes of this chapter.

(c) EMPLOYMENT.—For purposes of this chapter, the term "employment" means any service performed prior to 1955, which was employment for purposes of subchapter C of chapter 9 of the Internal Revenue Code of 1939 under the law applicable to the period in which such service was performed, and (A) any service, of whatever nature, performed after 1954 by an employee for the person employing him, irrespective of the citizenship or residence of either, (i) within the United States, or (ii) on or in connection with an American vessel or American aircraft under a contract of service which is entered into within the United States or during the performance of which and while the employee is employed on the vessel or aircraft it touches at a port in the United States, if the employee is employed on and in connection with such vessel or aircraft when outside the United States, and (B) any service, of whatever nature, performed after 1971 outside the United States (except in a contiguous country with which the United States has an agreement relating to unemployment compensation) by a citizen of the United States as an employee of an American employer (as defined in subsection (j)(3)), except—

(1) agricultural labor (as defined in subsection (k)) unless—

(A) such labor is performed for a person who—

(i) during any calendar quarter in the calendar year or the preceding calendar year paid remuneration in cash of $20,000 or more to individuals employed in agricultural labor (including labor performed by an alien referred to in subparagraph (B)), or

(ii) on each of some 20 days during the calendar year or the preceding calendar year, each day being in a different calendar week, employed in agricultural labor (including labor performed by an alien referred to in subparagraph (B)) for some portion of the day (whether or not at the same moment of time) 10 or more individuals; and

(B) such labor is not agricultural labor performed before January 1, 1993, by an individual who is an alien admitted to the United States to perform agricultural labor pursuant to sections 214(c) and 101(a)(15)(H) of the Immigration and Nationality Act;

(2) domestic service in a private home, local college club, or local chapter of a college fraternity or sorority unless performed for a person who paid cash remuneration of $1,000 or more to individuals employed in such domestic service in any calendar quarter in the calendar year or the preceding calendar year;

(3) service not in the course of the employer's trade or business performed in any calendar quarter by an employee, unless the cash remuneration paid for such service is $50 or more and such service is performed by an individual who is regularly employed by such employer to perform such service. For purposes of this paragraph, an individual shall be deemed to be regularly employed by an employer during a calendar quarter only if—

(A) on each of some 24 days during such quarter such individual performs for such employer for some portion of the day service not in the course of the employer's trade or business, or

(B) such individual was regularly employed (as determined under subparagraph (A)) by such employer in the performance of such service during the preceding calendar quarter;

(4) service performed on or in connection with a vessel or aircraft not an American vessel or American aircraft, if the employee is employed on and in connection with such vessel or aircraft when outside the United States;

(5) service performed by an individual in the employ of his son, daughter, or spouse, and service performed by a child under the age of 21 in the employ of his father or mother;

(6) service performed in the employ of the United States Government or of an instrumentality of the United States which is—

(A) wholly or partially owned by the United States, or

(B) exempt from the tax imposed by section 3301 by virtue of any provision of law which specifically refers to such section (or the corresponding section of prior law) in granting such exemption;

(7) service performed in the employ of a State, or any political subdivision thereof, or any instrumentality of any one or more of the foregoing which is wholly owned by one or more States or political subdivisions; and any service performed in the employ of any instrumentality of one or more States or political subdivisions to the extent that the instrumentality is, with respect to such service, immune under the Constitution of the United States from the tax imposed by section 3301;

(8) service performed in the employ of a religious, charitable, educational, or other organization described in section 501(c)(3) which is exempt from income tax under section 501(a);

(9) service performed by an individual as an employee or employee representative as defined in section 1 of the Railroad Unemployment Insurance Act (45 U.S.C. 351);

(10)(A) service performed in any calendar quarter in the employ of any organization exempt from income tax under section 501(a) (other than an organization described in section 401(a)) or under section 521, if the remuneration for such service is less than $50, or

(B) service performed in the employ of a school, college, or university, if such service is performed (i) by a student who is enrolled and is regularly attending classes at such school, college, or university, or (ii) by the spouse of such a student, if such spouse is advised, at the time such spouse commences to perform such service, that (I) the employment of such spouse to perform such service is provided under a program to provide financial assistance to such student by such school, college, or university, and (II) such employment will not be covered by any program of unemployment insurance, or

(C) service performed by an individual who is enrolled at a nonprofit or public educational institution which normally maintains a regular faculty and curriculum and normally has a regularly organized body of students in attendance at the place where its educational activities are carried on as a student in a full-time program, taken for credit at such institution, which combines academic instruction with work experience, if such service is an integral part of such program, and such institution has so certified to the employer, except that this subparagraph shall not apply to service performed in a program established for or on behalf of an employer or group of employers, or

(D) service performed in the employ of a hospital, if such service is performed by a patient of such hospital;

(11) service performed in the employ of a foreign government (including service as a consular or other officer or employee or a nondiplomatic representative);

(12) service performed in the employ of an instrumentality wholly owned by a foreign government—

(A) if the service is of a character similar to that performed in foreign countries by employees of the United States Government or of an instrumentality thereof; and

(B) if the Secretary of State shall certify to the Secretary of the Treasury that the foreign government, with respect to whose instrumentality exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States Government and of instrumentalities thereof;

(13) service performed as a student nurse in the employ of a hospital or a nurses' training school by an individual who is enrolled and is regularly attending classes in a nurses' training school chartered or approved pursuant to State law; and service performed as an intern in the employ of a hospital by an individual who has completed a 4 years' course in a medical school chartered or approved pursuant to State law;

(14) service performed by an individual for a person as an insurance agent or as an insurance solicitor, if all such service performed by such individual for such person is performed for remuneration solely by way of commission;

(15)(A) service performed by an individual under the age of 18 in the delivery or distribution of newspapers or shopping news, not including delivery or distribution to any point for subsequent delivery or distribution;

(B) service performed by an individual in, and at the time of, the sale of newspapers or magazines to ultimate consumers, under an arrangement under which the newspapers or magazines are to be sold by him at a fixed price, his compensation being based on the retention of the excess of such price over the amount at which the newspapers or magazines are charged to him, whether or not he is guaranteed a minimum amount of compensation for such service, or is entitled to be credited with the unsold newspapers or magazines turned back;

(16) service performed in the employ of an international organization;

(17) service performed by an individual in (or as an officer or member of the crew of a vessel while it is engaged in) the catching, taking, harvesting, cultivating, or farming of any kind of fish, shellfish, crustacea, sponges, seaweeds, or other aquatic forms of animal and vegetable life (including service performed by any such individual as an ordinary incident to any such activity), except—

(A) service performed in connection with the catching or taking of salmon or halibut, for commercial purposes, and

(B) service performed on or in connection with a vessel of more than 10 net tons (determined in the manner provided for determining the register tonnage of merchant vessels under the laws of the United States);

(18) service described in section 3121(b)(20);

(19) Service[58] which is performed by a nonresident alien individual for the period he is temporarily present in the United States as a nonimmigrant under subparagraph (F), (J), or (M) of section 101(a)(15) of the Immigration and Nationality Act, as amended, and which is performed to carry out the purpose specified in subparagraph (F), (J), or (M), as the case may be; or

(20) service performed by a full time student (as defined in subsection (q)) in the employ of an organized camp—

(A) if such camp—

(i) did not operate for more than 7 months in the calendar year and did not operate for more than 7 months in the preceding calendar year, or

(ii) had average gross receipts for any 6 months in the preceding calendar year which were not more than 33 1/3 percent of its average gross receipts for the other 6 months in the preceding calendar year; and

(B) if such full time student performed services in the employ of such camp for less than 13 calendar weeks in such calendar year.

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[58] As in original. Probably should be "service".

(d) Included and Excluded Service.—For purposes of this chapter, if the services performed during one-half or more of any pay period by an employee for the person employing him constitute employment, all the services of such employee for such period shall be deemed to be employment; but if the services performed during more than one-half of any such pay period by an employee for the person employing him do not constitute employment, then none of the services of such employee for such period shall be deemed to be employment. As used in this subsection, the term "pay period" means a period (of not more than 31 consecutive days) for which a payment of remuneration is ordinarily made to the employee by the person employing him. This subsection shall not be applicable with respect to services performed in a pay period by an employee for the person employing him, where any of such service is excepted by subsection (c)(9).

(e) State Agency.—For purposes of this chapter, the term "State agency" means any State officer, board, or other authority, designated under a State law to administer the unemployment fund in such State.

(f) Unemployment Fund.—For purposes of this chapter, the term "unemployment fund" means a special fund, established under a State law and administered by a State agency, for the payment of compensation. Any sums standing to the account of the State agency in the Unemployment Trust Fund established by section 904 of the Social Security Act, as amended (42 U.S.C. 1104), shall be deemed to be a part of the unemployment fund of the State, and no sums paid out of the Unemployment Trust Fund to such State agency shall cease to be a part of the unemployment fund of the State until expended by such State agency. An unemployment fund shall be deemed to be maintained during a taxable year only if throughout such year, or such portion of the year as the unemployment fund was in existence, no part of the moneys of such fund was expended for any purpose other than the payment of compensation (exclusive of expenses of administration) and for refunds of sums erroneously paid into such fund and refunds paid in accordance with the provisions of section 3305(b); except that—

(1) an amount equal to the amount of employee payments into the unemployment fund of a State may be used in the payment of cash benefits to individuals with respect to their disability, exclusive of expenses of administration;

(2) the amounts specified by section 903(c)(2) of the Social Security Act may, subject to the conditions prescribed in such section, be used for expenses incurred by the State for administration of its unemployment compensation law and public employment offices, and

(3) amounts may be deducted from unemployment benefits and used to repay overpayments as provided in section 303(g) of the Social Security Act.

(g) Contributions.—For purposes of this chapter, the term "contributions" means payments required by a State law to be made into an unemployment fund by any person on account of having individuals in his employ, to the extent that such payments are made by him without being deducted or deductible from the remuneration of individuals in his employ.

(h) COMPENSATION.—For purposes of this chapter, the term "compensation" means cash benefits payable to individuals with respect to their unemployment.

(i) EMPLOYEE.—For purposes of this chapter, the term "employee" has the meaning assigned to such term by section 3121(d), except that paragraph (4) and subparagraphs (B) and (C) of paragraph (3) shall not apply.

(j) STATE, UNITED STATES, AND AMERICAN EMPLOYER.—For purposes of this chapter—

(1) STATE.—The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, and the Virgin Islands.

(2) UNITED STATES.—The term "United States" when used in a geographical sense includes the States, the District of Columbia, the Commonwealth of Puerto Rico, and the Virgin Islands.

(3) AMERICAN EMPLOYER.—The term "American employer" means a person who is—

(A) an individual who is a resident of the United States,

(B) a partnership, if two-thirds or more of the partners are residents of the United States,

(C) a trust, if all of the trustees are residents of the United States, or

(D) a corporation organized under the laws of the United States or of any State.

An individual who is a citizen of the Commonwealth of Puerto Rico or the Virgin Islands (but not otherwise a citizen of the United States) shall be considered, for purposes of this section, as a citizen of the United States.

(k) AGRICULTURAL LABOR.—For purposes of this chapter, the term "agricultural labor" has the meaning assigned to such term by subsection (g) of section 3121, except that for purposes of this chapter subparagraph (B) of paragraph (4) of such subsection (g) shall be treated as reading:

"(B) in the employ of a group of operators of farms (or a cooperative organization of which such operators are members) in the performance of service described in subparagraph (A), but only if such operators produced more than one-half of the commodity with respect to which such service is performed;"

[(l) Repealed.[59]]

(m) AMERICAN VESSEL AND AIRCRAFT.—For purposes of this chapter, the term "American vessel" means any vessel documented or numbered under the laws of the United States; and includes any vessel which is neither documented or numbered under the laws of the United States nor documented under the laws of any foreign country, if its crew is employed solely by one or more citizens or residents of the United States or corporations organized under the laws of the United States or of any State; and the term "American aircraft" means an aircraft registered under the laws of the United States.

(n) VESSELS OPERATED BY GENERAL AGENTS OF UNITED STATES.—Notwithstanding the provisions of subsection (c)(6), service performed by officers and members of the crew of a vessel which would otherwise be included as employment under subsection (c) shall not be excluded by reason of the fact that it is performed on or in connection with an American vessel—

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[59] P.L. 83-767, §4(c); 68 Stat. 1135.

(1) owned by or bareboat chartered to the United States and

(2) whose business is conducted by a general agent of the Secretary of Commerce.

For purposes of this chapter, each such general agent shall be considered a legal entity in his capacity as such general agent, separate and distinct from his identity as a person employing individuals on his own account, and the officers and members of the crew of such an American vessel whose business is conducted by a general agent of the Secretary of Commerce shall be deemed to be performing services for such general agent rather than the United States. Each such general agent who in his capacity as such is an employer within the meaning of subsection (a) shall be subject to all the requirements imposed upon an employer under this chapter with respect to service which constitutes employment by reason of this subsection.

(o) SPECIAL RULE IN CASE OF CERTAIN AGRICULTURAL WORKERS.—

(1) CREW LEADERS WHO ARE REGISTERED OR PROVIDE SPECIALIZED AGRICULTURAL LABOR.—For purposes of this chapter, any individual who is a member of a crew furnished by a crew leader to perform agricultural labor for any other person shall be treated as an employee of such crew leader—

(A) if—

(i) such crew leader holds a valid certificate of registration under the Migrant and Seasonal Agricultural Worker Protection Act; or

(ii) substantially all the members of such crew operate or maintain tractors, mechanized harvesting or crop-dusting equipment, or any other mechanized equipment, which is provided by such crew leader; and

(B) if such individual is not an employee of such other person within the meaning of subsection (i).

(2) OTHER CREW LEADERS.—For purposes of this chapter, in the case of any individual who is furnished by a crew leader to perform agricultural labor for any other person and who is not treated as an employee of such crew leader under paragraph (1)—

(A) such other person and not the crew leader shall be treated as the employer of such individual; and

(B) such other person shall be treated as having paid cash remuneration to such individual in an amount equal to the amount of cash remuneration paid to such individual by the crew leader (either on his behalf or on behalf of such other person) for the agricultural labor performed for such other person.

(3) CREW LEADER.—For purposes of this subsection, the term "crew leader" means an individual who—

(A) furnishes individuals to perform agricultural labor for any other person,

(B) pays (either on his behalf or on behalf of such other person) the individuals so furnished by him for the agricultural labor performed by them, and

(C) has not entered into a written agreement with such other person under which such individual is designated as an employee of such other person.

(p) CONCURRENT EMPLOYMENT BY TWO OR MORE EMPLOYERS.—For purposes of sections 3301, 3302, and 3306(b)(1), if two or more related corporations concurrently employ the same individual and compensate such individual through a common paymaster which is one of such corporations, each such corporation shall be considered to have paid as remuneration to such individual only the amounts actually disbursed by it to such individual and shall not be considered to have paid as remuneration to such individual amounts actually disbursed to such individual by another of such corporations.

(q) FULL TIME STUDENT.—For purposes of subsection (c)(20), an individual shall be treated as a full time student for any period—

(1) during which the individual is enrolled as a full time student at an educational institution, or

(2) which is between academic years or terms if—

(A) the individual was enrolled as a full time student at an educational institution for the immediately preceding academic year or term, and

(B) there is a reasonable assurance that the individual will be so enrolled for the immediately succeeding academic year or term after the period described in subparagraph (A).

(r) TREATMENT OF CERTAIN DEFERRED COMPENSATION AND SALARY REDUCTION ARRANGEMENTS.—

(1) CERTAIN EMPLOYER CONTRIBUTIONS TREATED AS WAGES.—Nothing in any paragraph of subsection (b) (other than paragraph (1)) shall exclude from the term "wages"—

(A) any employer contribution under a qualified cash or deferred arrangement (as defined in section 401(k)) to the extent not included in gross income by reason of section 402(a)(8), or

(B) any amount treated as an employer contribution under section 414(h)(2) where the pickup referred to in such section is pursuant to a salary reduction agreement (whether evidenced by a written instrument or otherwise).

(2) TREATMENT OF CERTAIN NONQUALIFIED DEFERRED COMPENSATION PLANS.—

(A) IN GENERAL.—Any amount deferred under a nonqualified deferred compensation plan shall be taken into account for purposes of this chapter as of the later of—

(i) when the services are performed, or

(ii) when there is no substantial risk of forfeiture of the rights to such amount.

(B) TAXED ONLY ONCE.—Any amount taken into account as wages by reason of subparagraph (A) (and the income attributable thereto) shall not thereafter be treated as wages for purposes of this chapter.

(C) NONQUALIFIED DEFERRED COMPENSATION PLAN.—For purposes of this paragraph, the term "nonqualified deferred compensation plan" means any plan or other arrangement for deferral of compensation other than a plan described in subsection (b)(5).

(s) TIPS TREATED AS WAGES.—For purposes of this chapter, the term "wages" includes tips which are—

(1) received while performing services which constitute employment, and

(2) included in a written statement furnished to the employer pursuant to section 6053(a).

[(t) Repealed.[60]]

SEC. 3307. DEDUCTIONS AS CONSTRUCTIVE PAYMENTS.

Whenever under this chapter or any act of Congress, or under the law of any State, an employer is required or permitted to deduct any amount from the remuneration of an employee and to pay the amount deducted to the United States, a State, or any political subdivision thereof, then for purposes of this chapter the amount so deducted shall be considered to have been paid to the employee at the time of such deduction.

SEC. 3308. INSTRUMENTALITIES OF THE UNITED STATES.

Notwithstanding any other provision of law (whether enacted before or after the enactment of this section) which grants to any instrumentality of the United States an exemption from taxation, such instrumentality shall not be exempt from the tax imposed by section 3301 unless such other provision of law grants a specific exemption, by reference to section 3301 (or the corresponding section of prior law), from the tax imposed by such section.

SEC. 3309. STATE LAW COVERAGE OF SERVICES PERFORMED FOR NONPROFIT ORGANIZATIONS OR GOVERNMENTAL ENTITIES.

(a) State Law Requirements.—For purposes of section 3304(a)(6)—

(1) except as otherwise provided in subsections (b) and (c), the services to which this paragraph applies are—

(A) service excluded from the term "employment" solely by reason of paragraph (8) of section 3306(c), and

(B) service excluded from the term "employment" solely by reason of paragraph (7) of section 3306(c); and

(2) the State law shall provide that a governmental entity or any other organization (or group of governmental entities or other organizations) which, but for the requirements of this paragraph, would be liable for contributions with respect to service to which paragraph (1) applies may elect, for such minimum period and at such time as may be provided by State law, to pay (in lieu of such contributions) into the State unemployment fund amounts equal to the amounts of compensation attributable under the State law to such service. The State law may provide safeguards to ensure that governmental entities or other organizations so electing will make the payments required under such elections.

(b) Section Not To Apply to Certain Service.—This section shall not apply to service performed—

(1) in the employ of (A) a church or convention or association of churches, or (B) an organization which is operated primarily for religious purposes and which is operated, supervised, controlled, or principally supported by a church or convention or association of churches;

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[60] P.L. 101-140, §203(a)(2), repealed subsection (t).

(2) by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order;

(3) in the employ of a governmental entity referred to in paragraph (7) of section 3306(c), if such service is performed by an individual in the exercise of his duties—

(A) as an elected official;

(B) as a member of a legislative body, or a member of the judiciary, of a State or political subdivision thereof;

(C) as a member of the State National Guard or Air National Guard;

(D) as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or similar emergency; or

(E) in a position which, under or pursuant to the State law, is designated as (i) a major nontenured policymaking or advisory position, or (ii) a policymaking or advisory position the performance of the duties of which ordinarily does not require more than 8 hours per week;

(4) in a facility conducted for the purpose of carrying out a program of—

(A) rehabilitation for individuals whose earning capacity is impaired by age or physical or mental deficiency or injury, or

(B) providing remunerative work for individuals who because of their impaired physical or mental capacity cannot be readily absorbed in the competitive labor market,

by an individual receiving such rehabilitation or remunerative work;

(5) as part of an unemployment work-relief or work-training program assisted or financed in whole or in part by any Federal agency or an agency of a State or political subdivision thereof, by an individual receiving such work relief or work training; and

(6) by an inmate of a custodial or penal institution.

(c) NONPROFIT ORGANIZATIONS MUST EMPLOY 4 OR MORE.—This section shall not apply to service performed during any calendar year in the employ of any organization unless on each of some 20 days during such calendar year or the preceding calendar year, each day being in a different calendar week, the total number of individuals who were employed by such organization in employment (determined without regard to section 3306(c)(8) and by excluding service to which this section does not apply by reason of subsection (b)) for some portion of the day (whether or not at the same moment of time) was 4 or more.

SEC. 3310. JUDICIAL REVIEW.

(a) IN GENERAL.—Whenever under section 3303(b) or section 3304(c) the Secretary of Labor makes a finding pursuant to which he is required to withhold a certification with respect to a State under such section, such State may, within 60 days after the Governor of the State has been notified of such action, file with the United States court of appeals for the circuit in which such State is located or with the United States Court of Appeals for the District of Columbia, a petition for review of such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary of Labor. The Secretary of Labor thereupon shall file in the court the record of the proceedings on which he based his action as provided in section 2112 of title 28 of the United States Code.

(b) FINDINGS OF FACT.—The findings of fact by the Secretary of Labor, if supported by substantial evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Secretary of Labor to take further evidence, and the Secretary of Labor may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

(c) JURISDICTION OF COURT; REVIEW.—The court shall have jurisdiction to affirm the action of the Secretary of Labor or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28 of the United States Code.

(d) STAY OF SECRETARY OF LABOR'S ACTION.—

(1) The Secretary of Labor shall not withhold any certification under section 3303(b) or section 3304(c) until the expiration of 60 days after the Governor of the State has been notified of the action referred to in subsection (a) or until the State has filed a petition for review of such action, whichever is earlier.

(2) The commencement of judicial proceedings under this section shall stay the Secretary of Labor's action for a period of 30 days, and the court may thereafter grant interim relief if warranted, including a further stay of the Secretary of Labor's action and including such other relief as may be necessary to preserve status or rights.

SEC. 3311. SHORT TITLE.

This chapter may be cited as the "Federal Unemployment Tax Act."

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SEC. 3402. INCOME TAX COLLECTED AT SOURCE.

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(i) CHANGES IN WITHHOLDING.—

(1) IN GENERAL.—The Secretary may by regulations provide for increases in the amount of withholding otherwise required under this section in cases where the employee requests such changes.

(2) TREATMENT AS TAX.—Any increased withholding under paragraph (1) shall for all purposes be considered tax required to be deducted and withheld under this chapter.

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SEC. 3507. ADVANCE PAYMENT OF EARNED INCOME CREDIT.

(a) General Rule.—Except as otherwise provided in this section, every employer making payment of wages to an employee with respect to whom an earned income eligibility certificate is in effect shall, at the time of paying such wages, make an additional payment to such employee equal to such employee's earned income advance amount.

(b) Earned Income Eligibility Certificate.—For purposes of this title, an earned income eligibility certificate is a statement furnished by an employee to the employer which—

(1) certifies that the employee will be eligible to receive the credit provided by section 32 for the taxable year,

(2) certifies that the employee does not have an earned income eligibility certificate in effect for the calendar year with respect to the payment of wages by another employer, and

(3) states whether or not the employee's spouse has an earned income eligibility certificate in effect.

For purposes of this section, a certificate shall be treated as being in effect with respect to a spouse if such a certificate will be in effect on the first status determination date following the date on which the employee furnishes the statement in question.

(c) Earned Income Advance Amount.—

(1) In general.—For purposes of this title, the term "earned income advance amount" means, with respect to any payroll period, the amount determined—

(A) on the basis of the employee's wages from the employer for such period, and

(B) in accordance with tables prescribed by the Secretary.

(2) Advance amount tables.—The tables referred to in paragraph (1)(B)—

(A) shall be similar in form to the tables prescribed under section 3402 and, to the maximum extent feasible, shall be coordinated with such tables, and

(B) if the employee is not married, or if no earned income eligibility certificate is in effect with respect to the spouse of the employee, shall treat the credit provided by section 32 as if it were a credit—

(i) of not more than the credit percentage under section 32(b)(1) (without regard to subparagraph (D) thereof) for an eligible individual with 1 qualifying child and with earned income not in excess of the amount of earned income taken into account under section 32(a)(1), which

(ii) phases out between the amount of earned income at which the phaseout begins under section 32(b)(1)(B)(ii) and the amount of income at which the credit under section 32(a)(1) phases out for an eligible individual with 1 qualifying child, or[61]

(C) if an earned income eligibility certificate is in effect with respect to the spouse of the employee, shall treat the credit as if it were a credit determined under subparagraph (B) by substituting 1/2 of the amounts of earned income described in such subparagraph for such amounts.[62]

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[61] P.L. 101-508, §11111(c), amended subparagraph (B) in its entirety.

[62] P.L. 101-508, §11111(c), amended subparagraph (C) in its entirety.

(d) PAYMENTS TO BE TREATED AS PAYMENTS OF WITHHOLDING AND FICA TAXES.

(1) IN GENERAL.—For purposes of this title, payments made by an employer under subsection (a) to his employees for any payroll period—

(A) shall not be treated as the payment of compensation, and

(B) shall be treated as made out of—

(i) amounts required to be deducted and withheld for the payroll period under section 3401 (relating to wage withholding), and

(ii) amounts required to be deducted for the payroll period under section 3102 (relating to FICA employee taxes), and

(iii) amounts of the taxes imposed for the payroll period under section 3111 (relating to FICA employer taxes),

as if the employer had paid to the Secretary, on the day on which the wages are paid to the employees, an amount equal to such payments.

(2) ADVANCE PAYMENTS EXCEED TAXES DUE.—In the case of any employer, if for any payroll period the aggregate amount of earned income advance payments exceeds the sum of the amounts referred to in paragraph (1)(B), each such advance payment shall be reduced by an amount which bears the same ratio to such excess as such advance payment bears to the aggregate amount of all such advance payments.

(3) EMPLOYER MAY MAKE FULL ADVANCE PAYMENTS.—The Secretary shall prescribe regulations under which an employer may elect (in lieu of any application of paragraph (2))—

(A) to pay in full all earned income advance amounts, and

(B) to have additional amounts paid by reason of this paragraph treated as the advance payment of taxes imposed by this title.

(4) FAILURE TO MAKE ADVANCE PAYMENTS.—For purposes of this title (including penalties), failure to make any advance payment under this section at the time provided therefor shall be treated as the failure at such time to deduct and withhold under chapter 24 an amount equal to the amount of such advance payment.

(e) FURNISHING AND TAKING EFFECT OF CERTIFICATES.—For purposes of this section—

(1) WHEN CERTIFICATE TAKES EFFECT.—

(A) FIRST CERTIFICATE FURNISHED.—An earned income eligibility certificate furnished the employer in cases in which no previous such certificate had been in effect for the calendar year shall take effect as of the beginning of the first payroll period ending, or the first payment of wages made without regard to a payroll period, on or after the date on which such certificate is so furnished (or if later, the first day of the calendar year for which furnished).

(B) LATER CERTIFICATE.—An earned income eligibility certificate furnished the employer in cases in which a previous such certificate had been in effect for the calendar year shall take effect with respect to the first payment of wages made on or after the first status determination date which occurs at least 30 days after the date on which such certificate is so furnished, except that at the election of the employer such certificate may be made effective with respect to any payment of wages made on or after the date on which such certificate is so furnished. For purposes of this section, the term "status determination date" means January 1, May 1, July 1, and October 1 of each year.

(2) PERIOD DURING WHICH CERTIFICATE REMAINS IN EFFECT.—An earned income eligibility certificate which takes effect under this section for any calendar year shall continue in effect with respect to the employee during such calendar year until revoked by the employee or until another such certificate takes effect under this section.

(3) CHANGE OF STATUS.—

(A) REQUIREMENT TO REVOKE OR FURNISH NEW CERTIFICATE.—If, after an employee has furnished an earned income eligibility certificate under this section, there has been a change of circumstances which has the effect of—

(i) making the employee ineligible for the credit provided by section 32 for the taxable year, or

(ii) causing an earned income eligibility certificate to be in effect with respect to the spouse of the employee,

the employee shall, within 10 days after such change in circumstances, furnish the employer with a revocation of such certificate or with a new certificate (as the case may be). Such a revocation (or such a new certificate) shall take effect under the rules provided by paragraph (1)(B) for a later certificate and shall be made in such form as the Secretary shall by regulations prescribe.

(B) CERTIFICATE NO LONGER IN EFFECT.—If, after an employee has furnished an earned income eligibility certificate under this section which certifies that such a certificate is in effect with respect to the spouse of the employee, such a certificate is no longer in effect with respect to such spouse, then the employee may furnish the employer with a new earned income eligibility certificate.

(4) FORM AND CONTENTS OF CERTIFICATE.—Earned income eligibility certificates shall be in such form and contain such other information as the Secretary may by regulations prescribe.

(5) TAXABLE YEAR DEFINED.—The term "taxable year" means the last taxable year of the employee under subtitle A beginning in the calendar year in which the wages are paid.

SEC. 3508. TREATMENT OF REAL ESTATE AGENTS AND DIRECT SELLERS.

(a) GENERAL RULE.—For purposes of this title, in the case of services performed as a qualified real estate agent or as a direct seller—

(1) the individual performing such services shall not be treated as an employee, and

(2) the person for whom such services are performed shall not be treated as an employer.

(b) DEFINITIONS.—For purposes of this section—

(1) QUALIFIED REAL ESTATE AGENT.—The term "qualified real estate agent" means any individual who is a sales person if—

(A) such individual is a licensed real estate agent,

(B) substantially all of the remuneration (whether or not paid in cash) for the services performed by such individual as a real estate agent is directly related to sales or other output (including the performance of services) rather than to the number of hours worked, and

(C) the services performed by the individual are performed pursuant to a written contract between such individual and the person for whom the services are performed and such contract provides that the individual will not be treated as an employee with respect to such services for Federal tax purposes.

(2) DIRECT SELLER.—The term "direct seller" means any person if—

(A) such person—

(i) is engaged in the trade or business of selling (or soliciting the sale of) consumer products to any buyer on a buy-sell basis, a deposit-commission basis, or any similar basis which the Secretary prescribes by regulations, for resale (by the buyer or any other person) in the home or otherwise than in a permanent retail establishment, or

(ii) is engaged in the trade or business of selling (or soliciting the sale of) consumer products in the home or otherwise than in a permanent retail establishment,

(B) substantially all the remuneration (whether or not paid in cash) for the performance of the services described in subparagraph (A) is directly related to sales or other output (including the performance of services) rather than to the number of hours worked, and

(C) the services performed by the person are performed pursuant to a written contract between such person and the person for whom the services are performed and such contract provides that the person will not be treated as an employee with respect to such services for Federal tax purposes.

(3) COORDINATION WITH RETIREMENT PLANS FOR SELF-EMPLOYED.—This section shall not apply for purposes of subtitle A to the extent that the individual is treated as an employee under section 401(c)(1) (relating to self-employed individuals).

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[1] References are to sections of the Social Security Act.

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Federally-qualified health center services: 1861(aa)(3); 1905(l)(2)(A)
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Federal Supplementary Medical Insurance Trust Fund: 1841(a)
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Full-time life insurance salesman: 210(j)(3)
Fully insured individual: 214(a)
General benefit increase under this title: 215(i)(3)
General retirement system: 210(k)(4)(A)
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Governor: 1204
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Gross income from self-employment: 211(a)(end)
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Habilitation services: 1915(c)(5)
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Health maintenance organization: 1876(b)(1); 1903(g)(1), (m)(1)
Home dialysis supplies and equipment: 1881(b)(8)
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Home health services: 1861(m)
Home worker: 210(j)(3)(C)
Hospice care: 1861(dd)(1); 1905(o)
Hospice coinsurance period: 1813(a)(4)(A)
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  Human services program: 1136(f)(1)
  Husband: 216(f)
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  Including: 1101(b)
  Income: 1612(a)
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  Institutions of higher learning: 218(d)(6)(B)
  Insured status; disability benefits: 216(i)(3); 223(c)(1)
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  Intermittent: 1861(m)(end)
  Internee (Japanese): 231(a)
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  Item or service: 1128A(i)(3)
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  Legal process: 462(e)
  Lesser-of-cost-or-charges: 1814(j)(2)
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  Net earnings from self-employment: 211(a)
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  Nurse aide: 1819(b)(5)(F); 1919(b)(5)(F)
  Nurse practitioner: 1861(aa)(5)
  Nursing facility: 1919(a)
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  - Demonstration project: 1110(b)(2)
  - Medical assistance: 1915(d)(2)(A)
  - Recipient's interest: 1902(a)(19)
  - *See* Disclosure of Information
- Safety
  - Fire and safety: 1861(e)(end)(C)
  - Health and safety: 1861(e)(end)(A), (e)(end)(B), (s)(end), (cc)(2)(I); 1866(f)(1)
  - Life safety: 1819(d)(2), (d)(4)(B); 1919(d)(2), (d)(4)(B)
  - Quality and safety: 1902(a)(13)(A)
- Salesperson; employee: 210(j)(3)
- Sanction
  - *See* Penalty
- Saving Clause
  - Disability provision not applicable: 220
  - Maximum benefits: 203(a)(3)(B), (a)(5), (a)(9)
- Scale; relative value: 1842(j)(1)(D)(v)
- Scholarship: 209(a)(17); 1612(b)(7)
- School
  - Attendance
    - Full-time: 202(d)(7); 208
    - Regular: 1612(b)(1), (b)(7)
  - College or university: 707(d)(3)
  - Elementary school: 202(d)(7)(C)
  - Secondary school: 202(d)(7)(C)
  - Tuition and fees: 1612(b)(7)
  - Utah: 218(k)
  - *See* Education
- Screening guide; disclosure: 1106(d)
- Screening program; preadmission: 1919(e)(7)
- Screening services: 1902(a)(43); 1905(a)(4)(B)
- Secretary of Agriculture: 1631(m)
- Secretary, Board of Trustees
  - Administrator; HCFA: 1817(b); 1841(b)
  - Commissioner of Social Security: 201(c)
- Secretary
  - HHS: 1; 1101(a)(6)
- Secretary HHS; Authority and Duty
  - Accept
    - Defense Secretary; certification regarding internee (Japanese): 231(b)(3)
    - Federal agency determination; wages: 205(p)(1)
    - Gifts: 1113(e)
    - Panel's findings regarding utilization review: 1153(d)(2)
    - State agreement modification delivery: 218(c)(8)
    - State; payment of optional supplementation: 1616(d)
    - State waiver of nursing service requirement: 1919(b)(4)(C)
  - Access to
    - Claims processing information: 1816(b)(2)(B)
    - Contract documents: 1861(v)(1)(I)
    - Data: 1816(b)(2)(B)
    - Records and information: 1881(e)(2)(C)
    - Records of
      - Carrier: 1842(b)(3)(E)
      - State: 506(d)(1)
  - Adjust
    - Average standardized amount: 1886(d)(2)(F)
    - Classification and weighting factors: 1886(d)(4)(B)
    - DRG prospective payment rate: 1886(d)(2)(F), (d)(2)(H), (d)(3)(C), (d)(3)(E)
    - Fee schedule: 1833(l)(3)(A), (l)(4)
    - Hospital discharge classification and weighting factors: 1886(d)(4)(C)
    - Medical assistance amount: 1915(d)(5)(B)(iv)
    - Overpayment against Federal matching funds: 1914(a), (b)

Secretary HHS; Authority and Duty (Cont.)
  Adjust (Cont.)
    Overpayment; medicaid: 1885(a)
    Surgical procedures fee: 1833(i)(5)(B)
    Surgical procedures payment: 1833(i)(2)(A)
  Administer
    Affirmation or oath: 205(b)(1); 1874(c)
    Immunizations: 509(a)(2)
    Title XVIII: 1874(a)
  Affirm PRRB decision: 1878(f)(1)
  Agree
    Health care obligation violation: 1156(b)(1)
    Representation: 1816(d)
    State; disability determinations: 221(a)
  Allocate periodic benefit: 228(c)(5)
  Allot to State
    Child welfare payment: 421(a)
    Maternal and child health funds: 502(c)
    Medical and social services funds: 1620
  Allow grants: 426(b)(6)
  Amend utilization review contract: 1153(d)(2)
  Announce rate of payment: 1876(a)
  Apply
    Collection provisions: 1892(d)(6)
    Health and safety requirements: 1861(e)(end)(B)
    Hospital wage index: 1886(d)(8)(C)
    Laboratory trip fee: 1833(h)(3)
    Sanctions: 1833(f)(5)(D), (h)(5)(D); 1834(b)(5)(C); 1842(k), (l)(3), (m)(3), (n)(3)
    State law: 216(h)(2)(A)
  Appoint
    Advisory Council on Public Welfare: 1114(a)
    Advisory Council on Social Security: 706(a), (b), (e)
    Contract appeal review panel: 1153(d)(1), (d)(3)
    Medicare Geographical Classification Review Board: 1886(d)(10)(B)
    Physician Advisory Council: 1868
    Provider Reimbursement Review Board: 1878(h)
    Staff: 703
  Approve
    Classification of individuals: 1902(a)(10)
    Data processing plan: 402(e)(1); 452(d)(1)
    Facility or provider to make self-dialysis services available: 1881(b)(10)
    Geriatric medicine training programs: 1886(h)(5)(A)

Secretary HHS; Authority and Duty (Cont.)
  Approve (Cont.)
    Grant application: 502(a)(3)
    Home health aide training program: 1861(m)(4)
    Institution treating addict: 1611(e)(3)(A)
    Method in which group established: 1861(k)(2)
    Physician's disclosure notice: 1842(m)(1)
    Plan for Self-Support
      Blind: 1612(b)(4)(A)
      Disabled: 1612(b)(4)(B)
    Project: 1120
    Regulations of Secretary of Treasury: 464(b)(1)
    Services
      Consultative services: 1864(a)
      Health care services: 1876(c)(2), (e)(2)
      Inpatient services: 504(b)(1)
      Services under State plan: 1915(c)(1)
    State
      Plan: 1; 401; 402(b); 471(b); 1001; 1002(b); 1004; 1116(a)(1); 1402(b); 1601*; 1602(b)*, (b)(end)*; 1901; 1902(a)(25)(A)
      Procedures; fraud control: 1903(q)(1)
      Reduction plans: 1922(d)(2)
      Request; hospital reimbursement: 1886(c)(4), (c)(5)
      Systems: 1903(r)(4)(A)
    Training program: 1861(dd)(1)(D)(i)
  Ascertain
    Payment by Other Agency
      Internee (Japanese): 231(b)(3)
      Post-World War II wage credits: 217(e)(2)
    Primary insurance amount: 1839(a)(3)(B)
  Assign
    Home health agency: 1816(e)(4)
    Hospital discharge weighting factors: 1886(d)(4)(B)
    Provider to agency or organization: 1816(e)(1)
  Assume and exercise State authority: 1919(b)(4)(C)
  Assure
    Home health agency requirements and enforcement adequacy: 1891(b)
    Nursing facility requirements and enforcement adequacy: 1919(f)(1)
    Skilled nursing facility requirements and enforcement adequacy: 1819(f)(1)
    Surgical procedures notice: 1164(e)
  Assurance Regarding
    Eligible organization: 1876(c)(3)(D), (c)(3)(F)

- Secretary HHS; Authority and Duty (Cont.)
  - Assurance Regarding (Cont.)
    - Hospital reimbursement control system: 1886(c)(1)(B), (c)(1)(C)
  - Attorney; personal litigation: 205(l)
  - Authorize State drug rebate agreement: 1927(a)
  - Believe
    - Appropriate; when provider should be paid: 1815(a)
    - Assurances not met: 1886(c)(3)
    - Cardiac pacemaker device or lead: 1862(h)(3)
    - Disability has not ceased: 225(a)
    - Penalty possible: 1128A(k)
  - Board of Trustees member: 201(c); 1817(b); 1841(b)
  - Bring action to enjoin certain activities: 1128A(k)
  - Calculate hospital wage index: 1886(d)(8)(C)
  - Cancellation of approval of SNF or intermediate care facility: 1910(b)(1)
  - Carry on studies: 1875
  - Certification
    - Aid to blind: 1003(b)(2)
    - Amount of overpayment: 1870(b)
    - Compliance of Indian Health Service facility: 1880(c)
    - Entitlement of another spouse: 216(h)(1)(B)
    - Facility on Indian reservation: 1919(a)
    - Federal agency; Title II information about employment: 205(p)(2)
    - Health services shortage: 1861(aa)(2)
    - Managing trustee: 201(g)(1)(B); 1817(h); 1841(g), (h), (i)
    - Medicare supplemental policy: 1882(a), (c), (i)(2)(A)
    - Overpayment; individual deceased: 1817(g); 1841(f)
    - State amount: 403(b)(2)
    - State medicaid fraud control unit: 1903(q)
    - State nursing facility compliance: 1919(g)(1)(A)
    - To Secretary of Treasury
      - Amount to be transferred from or to trust fund: 1840(a)(2)
      - Child support amount: 452(b)
      - Self-employment income: 201(a)(4), (b)(2); 1817(a)(2)
      - Wages: 201(a)(3), (b)(1); 1817(a)(1)
  - Certifying Officer Function
    - Attorney; fee award: 206(a)(1), (b)(1); 1631(d)(2)
    - Carrier; SMIB: 1841(g)
    - Check; joint payees: 205(n)

- Secretary HHS; Authority and Duty (Cont.)
  - Certifying Officer Function (Cont.)
    - Civil Service Commission; SMIB: 1841(h)
    - Delegation authority: 205(l)
    - Disability benefits: 205(i)
    - Internee: 231(b)(3)
    - Litigation: 205(i)
    - Payee incompetency: 205(k)
    - Payment; general: 202(j)(1), (j)(5), (q)(2), (q)(3), (q)(4)
    - Payment to State: 3(b)(2); 221(e); 403(b)(2); 1003(b)(2); 1403(b)(2); 1603(b)(2)*
    - Railroad jurisdiction: 210(l)(4)(B)
    - Railroad Retirement Act eligibility: 205(i)
    - Railroad Retirement Board; SMIB: 1841(i)
    - Reliance on Department of Defense data: 204(a)(1)(A)
    - Representative payee: 205(j)
    - Retirement benefits: 205(i)
    - Survivor benefits: 205(i)
    - Veteran: 217(a)(2), (e)(2)
    - Veterans Administration jurisdiction: 217(b)(2)
  - Chairman, Supplemental Health Insurance Panel: 1882(b)(2)(A)
  - Collect Data; child support enforcement: 469
  - Compile and publish data on AFDC: 402(c)
  - Comply with requirements: 1631(e)(1)(B)
  - Compromise recovery of penalty: 1128A(f); 1140(c)(2)
  - Compute DRG prospective payment rate: 1886(d)(2)(D), (d)(3)(A)
  - Conduct
    - Blood donor locator service: 1141
    - Experiments; cost reduction: 1881(f)(2), (f)(3), (f)(7)
    - Health care research: 1143
    - Hearing, investigation, or other proceeding: 205(b)(1); 1631(c)(1); 1874(c)
    - Nursing facility survey: 1919(g)(3)
    - Study and evaluation; regulation of medicare supplemental policies: 1882(f)(1)(A)
    - Study of
      - Methods for increasing public participation: 1881(f)(4)
      - Patients ineligible for benefits: 1881(f)(6)
      - Reimbursement of physicians: 1881(f)(5)
  - Consider
    - Combined effect of impairments: 223(d)(2)(B)
    - Evidence: 223(d)(5)(B)
    - Prevailing charges justified: 1842(b)(4)(A)(iii)

- Secretary HHS; Authority and Duty (Cont.)
  - Consider (Cont.)
    - Principles generally applied: 1861(v)(1)(A)
  - Consolidate peer review areas: 1153(a)(2)
  - Consult
    - Accrediting bodies: 1863
    - Eligible organizations: 1876(c)(3)(A)(ii)
    - Federal agencies: 1136(f)(2)
    - Professional and network organizations: 1881(c)(6)
    - Professional and planning organizations: 1881(c)(5)
    - Railroad Retirement Board: 1840(b)(1)
    - Representative group: 1882(p)(1)(D)
    - Secretary of Agriculture: 1137(a)(4)
    - Secretary of Education: 483(b)
    - Secretary of Labor: 482; 483(b)
  - Continue agreement with State: 1843(b)
  - Contract
    - Authority: 502(a)(1); 1153(e); 1876(i)(5)
    - Ownership and control; disclosure: 1124(a)(1)
    - Payment of premiums: 1818(e)
    - Special data: 1874(b)
  - Coordinate surveys: 1861(dd)(4)(A)
  - Correct
    - Earnings record entry: 205(c)(4)
    - Effects of governmental error: 1837(h)
  - Decide
    - Amount payable; WWII service: 217(b)(2)
    - Creditability of WWII service: 217(a)(2)
    - Hearing on earnings record revision: 205(c)(7)
    - Payment to be denied: 1866(d)
    - Post-World War II deemed wages: 217(e)(2)
    - Rights of claimants: 205(b)(1)
  - Decrease
    - Payment amount; overpayment: 204(a)(1)(A)
    - Speciality board eligibility period: 1886(h)(5)(G)(iii)(II)
  - Deduct from provider or health maintenance organization or competitive medical plan: 1892(d)
  - Deduct; reimbursement from eligible organization: 1876(h)(2)
  - Deem
    - Appropriate
      - Adjustments in cost limits: 1888(c)
      - Exemptions; exceptions; adjustments: 1886(b)(4)(A)
      - Method for determining rehabilitation costs: 222(d)(4)

- Secretary HHS; Authority and Duty (Cont.)
  - Deem (Cont.)
    - Appropriate (Cont.)
      - Payment: 1886(d)(5)(C), (d)(5)(H), (d)(5)(I)
      - Surety bond: 1816(h); 1842(d)
      - Title XIX procedures: 1861(k)
      - Treating entity as meeting conditions: 1865(a)
      - Waiver Period
        - Fire and safety requirements: 1861(e)(end)(C)
        - Personnel requirement: 1861(e)(end)(A)
    - Efficient administration requires: 1814(a)(1); 1835(a)(1)
    - Fair and equitable: 1159
    - Necessary
      - Exemptions; exceptions; adjustments: 1886(b)(4)(A)
      - Information about internee (Japanese): 231(b)(4)
      - Installment payment: 1874(a)
      - Post-World War II service payments: 217(e)(3)
      - Reimbursement amount: 228(g)
      - Sums to put Trust Fund in same position: 1844(a)(2)
      - World War II service payments: 217(a)(3)
  - Define
    - Acute care hospital: 1886(c)(1)
    - Classes of members: 1876(a)(1)(B)
    - Diagnostic procedures: 1833(a)(2)(E)(ii)
    - Household: 412
    - Psychologist: 1861(s)(2)(H)
    - Risk of institutionalization: 1930(b)
    - Substantial contractual relationship: 1902(p)(2)(B)
    - *See* Secretary HHS; Authority and Duty; Regulations
  - Delegate
    - Authority: 1128A(j)(2), (j)(2)(sic)
    - Powers: 205(l); 1128A(j)
    - State coverage functions: 218(h)
  - Deny hospital payment: 1862(h)(4); 1886(f)(2)
  - Designate
    - Agency; hospice program: 1816(e)(5)
    - Agency to perform functions: 1816(e)(2)
    - Agent in lieu of peer review: 1861(v)(1)(G)(i)
    - Area; peer review: 1152(1)(A)
    - Area with shortage of health services or manpower: 1861(aa)(2)
    - Home and community care assessment instrument: 1929(c)(2)(C)(ii)
    - Home health agency survey instrument: 1891(d)

- Secretary HHS; Authority and Duty (Cont.)
  - Designate (Cont.)
    - Maternal and child health unit: 509(a)
    - Nursing facility resident assessment instrument: 1919(f)(6)(B)
    - Organ procurement agency: 1138
    - Peer review area: 1152(1)(A)
    - Regional agencies or organizations: 1816(e)(4)
    - Skilled nursing facility resident assessment instrument: 1819(f)(6)(B)
    - State agency to receive copy of JCAH survey: 1865(a)(2)
  - Determine
    - Advisory Committee membership: 479(a)(4)(A)
    - Age 17-65 disabled SSI beneficiaries: 1620(b)(2)
    - Agency's qualification as provider: 1866(h)
    - Allocation for overhead: 1888(b)
    - Allocation of periodic governmental payment: 202(b)(4)(C), (c)(2)(C), (e)(7)(C), (f)(2)(C), (g)(4)(C)
    - Amount
      - Benefit: 1611(c)(7)
      - Due; military service credits: 217(g)(1)
      - Payable to provider: 1815(a)
      - State recovery in prior period: 403(b)(2)
      - To Cover
        - Administrative costs and provide incentive: 1881(b)(6)(C)
        - Cost of personnel: 1881(b)(6)(B)
    - Appropriate
      - Commensurate rate of reduction: 1903(r)(4)(B)
      - Criteria: 1916(a)(3)
      - Disability investigations: 221(i)(1)
      - Expenses incurred: 1861(v)(5)(A)
      - Factors: 1876(a)(1)(B)
      - Fee schedule for nurse anesthetists: 1833(l)(4)
      - Frequency of continuing disability investigations: 221(i)(1), (i)(2)
      - Payment withheld from risk-sharing health maintenance organization: 1876(g)(5)
      - Period of need: 402(a)(13)(A), (a)(13)(B)
      - Readmission case review: 1154(a)(13)
      - System exceptions: 1886(g)(1)
      - Time; reimbursement; military service credits: 217(g)(2)
- Secretary HHS; Authority and Duty (Cont.)
  - Determine (Cont.)
    - Appropriate (Cont.)
      - Trust fund; travel expense payment: 201(j)
    - Assistance based on need: 1616(a)
    - Assistance payments duration: 228(d)
    - Audit necessary: 506(a)(1)
    - Basis equivalent to monthly payment: 215(a)(7)(C)(i)
    - Capital expenditures: 1122(j)
    - Certify; compliance of Indian Health Service facility: 1880(c)
    - Certify; Congress; no increase in payment: 1814(j)(1)
    - Cessation of disability: 1631(m)(2)(B)
    - Charge: 1128(b)(6)
    - Charge not reasonable: 1842(b)(9)(A)(i)
    - Child not in care: 203(c)
    - Child of deceased: 204(d)(5); 1870(e)(6)
    - Circumstances: 1842(b)(7)(D)(i)
    - Claim for payment incorrect: 1128A(a)
    - Clinic services utilization review need and feasibility: 1861(aa)(2)(I)
    - Competency evaluation program standards met: 1891(a)(3)(D)
    - Conditions for
      - Mental retardation grants: 1704
      - Termination: 1866(b)(2)
    - Conditions inappropriate for hospital: 1883(f)
    - Continuing disability despite SGA: 1619(a)
    - Contract period: 1876(i)(1)
    - Contribution and benefit base: 230(a)
    - Cost
      - Carrier administration; necessary and proper: 1842(c)(1)(A)(i)
      - Disclosure of information: 1106(b)
      - Individual or entity: 1128(b)(6)
      - Living adjustment: 215(i)(2)(A)(i)
      - Period; reporting: 1886(b)(5)
      - Reason for discontinuing reimbursement: 1814(b)(3)
    - Data to evaluate unit: 1903(q)(7)
    - Deductions reasonably expected: 203(h)(3)
    - DRG prospective payment rate: 1886(d)(2), (d)(3)
    - Disability: 221(a), (c)(1)
    - Disability issues: 221(g)
    - Drugs and biologicals needed: 1861(aa)(2)(H)

- Secretary HHS; Authority and Duty (Cont.)
  - Determine (Cont.)
    - Drug use review program expense: 1903(a)(3)(D)
    - Earnings test deductions; amount and time: 203(b)(1)
    - Earnings test exempt amount: 203(f)(8)(A), (f)(8)(B)
    - Eligible organization: 1876(i)(6)(A)
    - Eligible organization's allocation: 1876(a)(5)
    - Eligible organization's capacity: 1876(c)(3)(A)(i)
    - Employment: 205(p)(1)
    - Enrollment discouraged: 1876(c)(2)
    - Enrollment experience; average: 1876(g)(2)
    - Enrollment requirement noncompliance: 1876(f)(3)
    - Entity control: 1128(b)(8)
    - Entity's services adequacy: 1128(b)(6)
    - Equipment lifetime: 1834(a)(7)(C)
    - Evidence adequacy: 205(j)(2); 1631(a)(2)(B)
    - Evidence standard; expedited payment of benefits: 205(q)(3)
    - Facility's cooperation: 1881(c)(3)
    - Facility's qualification for certification: 1881(c)(4)
    - Federal share
      - Aid to aged, blind, or disabled: 1603(b)(3)*
      - Aid to blind: 1003(b)(2)
    - Good Cause
      - Charges: 1128(b)(6)(A)
      - Failure to pay overdue premium: 1838(b)
    - Grant payment: 426(c); 705(f)(2); 707(c); 1110(a)(3); 1113(a)(3); 1704; 1864(b)
    - Head of household: 1614(c)
    - Health and safety problem: 1866(f)(1)
    - Health care obligation violation: 1156(b)(1)
    - Health manpower shortage: 1861(aa)(2)(end)(IV)
    - Hearing decision finality: 1631(c)(3)
    - Hearing requirements: 416(b)
    - Hearing rights will not be exercised: 1879(d)
    - HMO's services adequacy: 1128(b)(6)
    - Hospital beds not in excess: 1861(v)(1)(G)(i)(end)
    - Hospital location meets requirement: 1886(d)(5)(D)(iii)(I)
    - Hospital participation period: 1861(e)(end)(B)

- Secretary HHS; Authority and Duty (Cont.)
  - Determine (Cont.)
    - Hospital providing unnecessary care: 1886(f)(2)
    - Hospital's costs: 1886(d)(2)(A); 2003(b)(end)
    - Impairment nonexistent: 1631(m)(2)(B)
    - Impairment not disabling: 1631(m)(2)(B)
    - Inequity; Deeming Income and Resources
      - Parent to child: 1614(f)(2)
      - Spouse: 1614(f)(1)
    - Information appropriate: 1842(h)(3)(B)
    - Information; data processing: 452(d)(1)(G)
    - Information necessary: 1115(d)(5)
    - Information reliable and available: 1611(c)(4)(A)
    - Information would not serve program purpose: 1106(c)
    - Institution's compliance with requirements: 1902(a)(33)(B)
    - Institution's qualification as provider: 1866(h)
    - Intermediary data timeliness: 1153(g)
    - Items; medical necessity: 1128(b)(6)(B); 1881(e)(3)
    - Length of coverage: 1812(f)(1)
    - Management information system implementation failure: 402(e)(2)(C)
    - Marital status: 1614(d)
    - Marriage requirement waiver inapplicable: 216(k)
    - Marriage validity: 216(h)(1)(B)
    - Medical assistance percentage; Federal: 1905(b)
    - Medicare supplemental policies: 1882(b)
    - National adjusted DRG prospective payment rate: 1886(d)(2), (d)(3)
    - Necessary
      - Audit of State records: 506(a)(1); 1902(a)(42)
      - Costs; disabled person: 223(d)(4)
      - Safeguards; death record: 205(r)(5)
    - Need; SSI benefits: 1611(c)(1)
    - Needed drugs and biologicals: 1861(aa)(2)(H)
    - Nominal amount; regulations: 1916(a)(3), (b)(3)
    - OASDI fund ratio: 215(i)(2)(C)(ii)
    - Optional State supplementation not paid beneficiary: 1631(i)(2)
    - Overpayment or underpayment to State: 458
    - Parent Locator Service documents: 453(d)

- Secretary HHS; Authority and Duty (Cont.)
  - Determine (Cont.)
    - Patients' health and safety not adversely affected: 1861(e)(end)(A)(iii)
    - Payment
      - Enrollees: 1876(a)(1)(A)
      - Experience basis: 1886(c)(1)(end)
      - Inconsistency with title XVIII: 1870(c)
      - Incorrect: 1870(c)
      - Incorrect; assignment: 1842(b)(3)(B)(ii)
      - Indians: 428(a)
      - Period: 1881(g)(1)
      - Prohibited: 1866(a)(1)(B)
      - Recoupment: 1870(b)(1)
    - Peer review factors: 1153(a)(2)(B)
    - Peer review organization: 1153(b)(1)
    - Peer review organization costs: 1876(i)(7)(C)
    - Penalty amount: 1882(t)
    - Person's attainment of age 65: 1837(d)
    - Population ratio: 2003(b)(end)
    - Premium amount: 1818(d)(2)
    - Provider or person without fault: 1870(b)(1)
    - Provider's cooperation: 1881(c)(3)
    - Provider serving public generally as community institution: 1814(c); 1835(d)
    - Puerto Rico prospective payment rate: 1886(d)(9)(B), (d)(9)(C)
    - Quality control and peer review: 1832(a)(2)(F)(ii)
    - Quarter of coverage requirements: 213(d)(2)
    - Rate
      - Interest; State overpayment: 1903(d)(5)
      - Payment: 1876(c)(3)(A)(ii), (e)(3)(A)
    - Reallotment of funds to State: 1620(b)(4)
    - Reasonable
      - Expenses: 1157(d)
      - Value; resource exclusion: 1613(a)(2)(A)
    - Regional adjusted DRG prospective payment rate: 1886(d)(2), (d)(3)
    - Regulations
      - Data to evaluate unit: 1903(q)(7)
      - Employee carrier or intermediary: 1866(a)(1)(D)
      - Necessary drugs or services; disabled person: 1612(b)(4)(B)(ii); 1614(a)(3)(D)

- Secretary HHS; Authority and Duty (Cont.)
  - Determine (Cont.)
    - Regulations (Cont.)
      - Payment to excluded individual or entity: 1862(e)(2)
    - Rehabilitation program approved by court: 202(x)(1)
    - Reimbursement
      - Assistants at surgery: 1842(b)(7)(D)(iii)
      - Internee (Japanese): 231(c)
      - Rehabilitation services: 222(d)(4)
    - Representative past period: 1842(b)(7)(A)(i)(III)
    - Representative payee advisable: 205(j)(1)
    - Requirements
      - Equal to JCAH accreditation: 1861(f)
      - Not met: 1866(f)(1)
      - Standards; support: 454(13)
    - Residence of claimant: 1128A(f)
    - Room other than semiprivate; reason: 1861(v)(3)
    - Rural area: 1861(e)(end)
    - Services; necessity or quality: 1128(b)(6)
    - Special consideration: 1876(i)(4)
    - Spouse of deceased: 1870(e)(2), (e)(5)
    - Standard imposed by JCAH: 1865(a)
    - State
      - Administrative expenses: 474(b)(4)(C)
      - Aid to aged, blind, or disabled: 1603(b)(2)*
      - Failure to correct deficiencies: 1922(e)
      - Failure to meet mechanization requirement: 1903(r)(1)(C)
      - Failure to meet waiver assurances: 1915(d)(3)
      - Fire and safety codes adequacy: 1861(e)(end)(C)
      - Health programs funds: 502(c)(1)
      - Inability to comply: 1903(r)(8)(A)
      - Income: 424
      - Maternal and child health funds: 502(c)(1)
      - Need for funds; reallotment: 424
      - Payment: 221(e); 455(b)(2)
      - Population ratio: 2003(b)
    - Student status: 1612(b)(1); 1614(c)
    - SMIB acturial rate: 1839(a)(1), (a)(4)
    - SMIB monthly premium: 1839(a)(3)
    - Surviving spouse; underpayment of benefits: 202(d)(1), (d)(4)
    - Systems: 403(a)(3)(B); 1886(c)(1)(D), (c)(1)(E), (c)(3), (c)(5)(B)

- Secretary HHS; Authority and Duty (Cont.)
  - Determine (Cont.)
    - Table of benefits; methodology: 215(a)(6)(B)
    - Title XIX utilization review applicability under Title XVIII: 1861(k)
    - Training and competency evaluation program standards met: 1891(a)(3)(D)
    - Trust fund to be charged; rehabilitation costs: 222(d)(4)
    - Under Regulations
      - Blind or disabled despite SGA; Title XIX or XX: 1619(b)
      - Person to be paid for services: 1870(e)(1)
      - Person who paid premium: 1870(g)
      - Professional [medical] services: 1887(a)(1)
    - U.S. pro rata share of State recovered funds: 474(d)(3)
    - Vocational rehabilitation duration: 225(b); 1631(a)(6)(B)
    - Wages: 205(p)(1)
    - Widow/widower; living with: 202(i)
    - Work outside U.S.; deductions from benefits: 203(c)
    - Work for gain: 222(c)(2)
  - Develop
    - Appeal procedures: 1846(b)(1)(A); 1891(f)(1)
    - Child welfare services plan: 422(a)
    - Conditions for approval: 1903(r)(4)(A)
    - Disability determination procedures: 221(b)(3)(A)
    - Discharge planning process guidelines and standards: 1861(ee)(2)
    - Food stamp application procedures: 1631(m)
    - Home health agency survey protocol: 1891(c)(2)(C)(ii)
    - Hospital payment system: 1135(a)
    - Index of costs of practice: 1845(e)(4)(C)
    - Job program performance standards: 487
    - Legislative proposals: 1135(c)
    - Medical assistance increase method: 1915(d)(5)(B)(iii)
    - Medical care guides and standards: 1112
    - Medical history: 223(d)(5)(B)
    - Nursing facility administrator standards: 1919(f)(4)
    - Nursing facility survey protocol: 1919(g)(2)(C)(i)
    - Outpatient services payment system: 1135(d)(6)(A)
    - Overpayment procedures: 203(h)(4)
    - Penalty procedures: 1846(b)(3)

- Secretary HHS; Authority and Duty (Cont.)
  - Develop (Cont.)
    - Performance evaluation procedures and standards: 1816(f)
    - Radiologist value scale: 1834(b)
    - Sanction procedures: 1891(f)(3)
    - Sanctions: 1846(b); 1891(f)(1)
    - Second opinion measures: 1164(c)(1)
    - Services criteria: 1930(c)
    - Services participation goals: 1905(r)(end)
    - Skilled nursing facility administrator standards: 1819(f)(4)
    - Standards, requirements, and conditions for systems: 1903(r)(6)(A), (r)(6)(B)
    - State determination criteria: 1919(f)(8)(A)
    - State systems costs: 1903(r)(6)(I)
    - State systems performance standards: 1903(r)(6)(J)
    - State waiver performance monitoring criteria and procedures: 1919(f)(9)
    - SSI application system: 1631(m)
    - Surgical procedures payment system: 1135(d)(1)
    - System approval conditions: 1903(r)(4)(A)
    - System; expenditures: 1845(e)(5)
    - System; identification coding: 1903(r)(6)(H)(i)
    - System reapproval procedures: 1903(r)(6)(B)
    - System standards requirements, and conditions: 1903(r)(6)(A), (r)(6)(B)
  - Direct State agency to exclude from participation: 1128; 1128A(a)
  - Disallow intermediate care facility's cost: 1922(e)(2)
  - Disapprove State plan: 1902(b), (c)
  - Disbursing officer function: 205(r)(2); 222(d)(1); 422; 423(b)(2); 455(a), (b)(2); 1122(c); 1157(d); 1602; 1603(b)(2)*; 1615(d); 1616(a); 1620(d); 1631(a)(4), (g)(1), (h), (i)(2); 1861(v)(5)(B); 1864(b); 1866(a)(1)(F)(i); 1876(a)(1)(D); 1881(b)(3), (b)(4); 1903(a), (d)(2); 2002(b)
  - Discontinue payments: 1886(c)(3)
  - Discretion; ambulatory surgical procedures: 1154(d)
  - Dispute with State: 474(b)(4)(C), (b)(5)(D)
  - Disseminate
    - State systems costs: 1903(r)(6)(I)
    - State systems performance standards: 1903(r)(6)(J)
  - Duties under SSAct: 702; 1106(a)
  - Earnings Record
    - Correct before final: 205(c)(4)

Secretary HHS; Authority and Duty (Cont.)
  Earnings Record (Cont.)
    Establish; maintain: 201(a)(3), (a)(4), (b)(1), (b)(2), (g)(2); 205(c)(2)(A); 1817(a)(1), (a)(2), (f)(1)
    Revision: 205(c)(5)
  Effectuate hospital cost reporting: 1886(f)(1(B)
  Election of month unearned income counts: 1611(c)(3)
  Enrollment of individuals with eligible organization: 1876(c)(3)(C)
  Ensure certifications of payments: 205(j)(2)
  Ensure determinations of payments reviewed: 1631(a)(2)(B)
  Enter into Agreement with
    Agency or organization: 1816
    Attorney General
      Aliens: 415(c)(2); 1621(d)(2)
      Social security numbers: 205(c)(2)(B)(iii)
    Carrier: 1842(h)(3)(B)
    Hospital
      Demonstration project: 1883(g)
      Extended care services: 1883(a)(1), (b)
    Interstate instrumentality; coverage: 218(g)(1)
    Person: 1892
    Secretary of Labor; State; work incentive program: 407(e)
    Secretary of State; aliens: 415(c)(2); 1621(d)(2)
    Secretary of the Treasury; tax returns: 232
    State (or State Agency)
      Certification of accredited hospitals: 1864(c)
      Coverage: 218(a)(1), (n)
      Determination
        Hospital or skilled nursing facility: 1864(a)
        Parent locatability: 453(f)
      Disability determinations: 221(b); 1633
      Enrollment of medical and public assistance recipients: 1843(a)
      HHS determination of medicaid eligibility: 1634(a)
      Information; disability offset: 224(h)(2)
      Issuance of social security numbers: 205(c)(2)(B)(iii)
      Modification of agreement: 1843(g)(1), (h)(1)
      Nursing facility residents needing treatment: 1919(e)(7)(E)
      Optional State supplementation: 1616(a), (b), (d); 1618(a)
      Parent Locator Service use in parental kidnaping: 463(a)

Secretary HHS; Authority and Duty (Cont.)
  Enter into Agreement with (Cont.)
    State (or State Agency) (Cont.)
      Reimbursement from State; medicaid eligibility determination: 1634(a)
      Secretary of Labor; work incentive program: 407(e)
      State interim assistance reimbursement: 1631(g)(4)
      Unemployment: 1115(d)
    Teaching hospital: 1814(g)(1); 1835(e)(1)
  Enter into Contract with
    Carrier: 1842(a), (b)(2)
    Eligible organization: 1876(g)(1), (h)(1)
    Entity with conflict of interest: 1153(b)(2)(B)
    Physicians: 1842(a)
    Utilization and quality control peer review organizations: 1153(b)(1); 1862(g)
  Establish
    Accountability monitoring system: 205(j)(3)(B), (j)(3)(C); 1631(a)(2)(C)(i), (a)(2)(C)(iii)
    Administration standards: 1816(f)
    Advisory Committee: 479(a)
    Advisory council: 1122(i)(3)
    Basis for
      Calculating amounts for items and services: 1866(a)(2)(A)
      Determining amounts payable for dialysis services: 1881(b)(2)(A)
    Blood donor locator service: 1141
    Carrier performance standards: 1842(b)(2)(B)
    Case mix index: 1886(a)(1)(B)(i)
    Charge; primary care: 1842(b)(4)(A)(vi)
    Child support organizational unit: 452(a)
    Competency evaluation program standards: 1891(a)(3)(D)
    Criteria
      Administration: 1816(f)
      Extended care services availability: 1861(v)(1)(G)(i)
      Hospice care: 1861(dd)(1)(end)
      Hospital reclassification: 1886(d)(5)(C)
    Data reporting standards: 1845(e)(3)
    Date transitional allowance effective: 1884(c)(3)
    Dialyzer filter protocols: 1881(f)(7)
    DRG prospective payment rate: 1886(d)(2)(G), (d)(3)(D)
    Enrollment period: 1837(d); 1876(c)(3)(A)(ii)
    Equipment
      Lifetime: 1834(a)(7)(C)

- Secretary HHS; Authority and Duty (Cont.)
  - Establish (Cont.)
    - Equipment (Cont.)
      - Maintenance/servicing fee: 1834(a)(7)(A)(iii)(I)
      - Training standards: 1861(n)
    - Error rates: 1903(u)(3)(A)
    - Fee for costs of collecting sample: 1833(h)(3)
    - Fee schedule for nurse anesthetists services: 1833(l)(1), (l)(4)
    - Fee schedules for tests: 1833(h)
    - File of convictions, revocations, and terminations: 205(j)(2)
    - Formats and procedures: 1137(a)(4); 1927(b)(2)
    - FTE resident computation rules: 1886(h)(4)
    - Guidelines
      - Charges for eyeglasses and lenses: 1842(b)(11)
      - Home health agency corrective actions approval: 1891(e)(4)
      - Home and community care guidelines: 1929(c)(2)(C)
      - Nursing facility corrective actions approval: 1919(h)(3)(D)
      - Surgical procedures reviewed: 1164(b)(2)(A)
    - Home health agency surveyor qualifications: 1891(c)(2)(C)(iii)(I)
    - Hospital discharge classification: 1886(d)(4)(A)
    - Hospital Medicare patient load: 1886(h)(3)(C)
    - Individual qualified to fit and furnish shoes: 1861(s)(12)
    - Information procedures and safeguards: 1160(b)
    - Nurse Aide
      - Competency evaluation program requirements: 1819(f)(2)(A); 1919(f)(2)(A)
      - Training and competency requirements: 1819(f)(2)(A); 1919(f)(2)(A)
    - Nursing Facility
      - Administration criteria: 1919(f)(5)
      - Data set use guidelines: 1919(f)(6)(A)
      - Survey team qualifications: 1919(g)(2)(C)(ii)
    - Overhead; fair fee: 1833(i)(2)(B)
    - Payment guidelines: 1154(a)(2)(end)
    - Payment rate for laboratory test: 1833(h)(6)
    - Payment system: 1886(g)(1)
    - Peer review areas: 1153(a)(1), (a)(2)(B)
    - Physician identifier system: 1842(r); 1902(x)

- Secretary HHS; Authority and Duty (Cont.)
  - Establish (Cont.)
    - Procedures
      - Administration of SSI program, including evidence and proof: 1631(d)(1)
      - Assignment of right to payment: 1842(h)(3)(B)
      - Expedited payment: 205(q)(1)
      - Medicare supplemental policies: 1882(a)
      - Transitional allowance: 1884(a)
    - Provider Reimbursement Review Board: 1878(a)
    - Reasonable charge: 1842(b)(9)(A)(ii)
    - Regulations
      - Contract percentage; reasonable: 1887(b)(2)(B)
      - Disclosure of information: 1137(a)(5)(B)
      - Reasonable compensation equivalent: 1887(a)(2)(B)
    - Renal disease network areas: 1881(c)(1)(A)
    - Renal disease protocols: 1881(f)(7)
    - Renal disease registry: 1881(c)(7)
    - Reporting requirements: 403(e); 1882(b)(1)(F)
    - Report review procedures: 205(j)(3)(A); 1631(a)(2)(C)(i)
    - Residency or fellowship program criteria: 1886(h)(5)(F)(ii)
    - Services: 2006(c)
    - Skilled Nursing Facility
      - Administration criteria: 1819(f)(5)
      - Data set use guidelines: 1819(f)(6)(A)
    - State appeal guidelines: 1819(f)(3); 1919(f)(3)
    - State error rate: 403(i)(3)(A)
    - Surgical procedure fee: 1833(i)(5)(B)
    - Target reimbursement rate for home dialysis: 1881(b)(6)
    - Title II procedures: 205(a)
    - Training and competency evaluation program standards: 1891(a)(3)(D)
    - Utilization guidelines: 1862(f)
  - Estimate
    - Actuarial rate: 1818(d)(1)
    - Amount
      - Necessary to Pay Half of Benefits and Costs
        - Disabled under 65: 1839(a)(4)
        - Sixty-five and over: 1839(a)(1)
      - Offset by underpayment to State: 1003(b)(2)
      - Payable; general: 709(b)(2); 1876(a)(4)

- Secretary HHS; Authority and Duty (Cont.)
  - Estimate (Cont.)
    - Amount (Cont.)
      - Payable to State: 3(b)(1); 403(b)(1); 423(b)(1); 455(b)(1); 458(e); 474(d)(1); 705(d), (f)(2); 1003(b)(1); 1403(b)(1); 1603(b)(1)*; 1903(d)(1)
      - Reimbursement: 1886(d)(5)(E)(i)
    - Cost of home dialysis supplies: 1881(b)(6)(A)
    - Disbursements for quarter: 201(g)(1)(A)
    - Effect of conditions on amount due State: 403(b)(2)
    - Extended care reasonable cost per diem: 1813(a)(3)(B)
    - Individual who could be covered: 1844(b)
    - Overpayment to State: 1903(d)(5)
    - Premium: 1876(e)(3)(B)
    - Reasonable cost of service: 1814(h)(2)
    - Wages deemed paid: 229(b)
  - Evaluate
    - Home health agency assessment process: 1891(d)(2)
    - Peer review organization: 1153(c)(2)
  - Examine witnesses: 205(b)(1)
  - Exclude drugs: 1927(c)(2)(B)
  - Exclude from participation: 1128; 1128A(a); 1156(b)(1); 1892(a)(2)(C)(ii), (a)(3)(B)
  - Exempt State: 466(d)
  - Expend to carry out functions: 703
  - Extend Time Limit
    - Filing for court review of final decision: 205(g)
    - Implementation of State system: 402(e)(2)(C)
  - Extrapolate percentage increase: 1902(a)(13)(C)
  - File with Court
    - Certified copy of transcript: 205(g)
    - Record after remand: 205(g)
  - Find
    - Acceptable
      - Prevailing charge: 1842(b)(3)
      - Statistical data and methodology: 1842(b)(3)
    - Access needed to assure correctness: 1842(b)(3)(E)
    - Accreditation by AOA assures conditions met: 1865(a)
    - Adequate services available: 1915(a)(1)(B)
    - Amount due for prior quarter: 403(b)(2)
    - Appropriate
      - Contract terms: 1876(i)(3)(D)
      - Desirable; supportive services: 1881(b)(9)(D)

- Secretary HHS; Authority and Duty (Cont.)
  - Find (Cont.)
    - Appropriate (Cont.)
      - Institution certified by State: 1864(a)
      - Survey: 1864(c)
    - Benefits equal in value: 1876(g)(2)
    - Block grant funds misuse: 506(b)(2)
    - Burial fund use: 1613(d)(3)
    - Carrier performance inadequate or inefficient: 1842(b)(5)
    - Compliance
      - Failure
        - Management information system: 402(e)(2)(B)
        - Requirements: 452(d)(2)(B)
      - Institutions accredited by JCAH: 1865(a)
      - Provider: 1866(f)(3)
      - Renal dialysis facility: 1881(g)(2)
      - State supplementation: 1618(b)
    - Consistent with
      - Effective and efficient administration: 1816(b)(1)(A)
      - Title XVIII; shorter period: 1842(b)(3)(B)(ii); 1866(a)(1)(B); 1870(b), (c)
    - Contract failure: 1876(i)(1)
    - Data not available: 1876(e)(1), (e)(3)
    - Demonstration project suitability: 1916(f)
    - Desirable; recommendations for legislative change: 1881(f)(8)
    - Efficient and effective; carrier: 1842(b)(2)(A)
    - Enrollment experience insufficient: 1876(g)(2)
    - Enrollment failure: 1837(d)
    - Equipment economical and efficient: 1881(e)(1)
    - Facts: 205(b)(1), (c)(7); 1631(c)(1)
    - Failure to Comply
      - Management information system: 402(e)(2)(B)
      - Prescribed requirements: 452(d)(2)(B)
    - Fair compensation; provider: 1814(b), (k)
    - Feasible and appropriate; return on capital: 1881(b)(2)(C)
    - Fraud elimination costs: 1903(a)(6)
    - Good cause: 1128(b)(6)(A); 1927(b)(4)
    - Government
      - Error: 1837(h)
      - Inaction: 1837(h)
      - Misrepresentation: 1837(h)
    - Home health agency in compliance: 1891(f)(2)(C)
    - Hospital closure; valid: 1884(b)

- Secretary HHS; Authority and Duty (Cont.)
  - Find (Cont.)
    - Incapability; application: 216(i)(2)(F)(i), (i)(2)(F)(ii)(III)
    - Individual outside U.S.: 202(t)(1)(A)
    - Institution has significant deficiencies: 1865(b); 1922(a)
    - Institution's compliance: 1865(a)(end)
    - Justified; higher prevailing charge: 1842(b)(3)
    - Limits; adjust; family size: 1903(f)(1)(B)(ii)
    - Maternal and child health payment payable: 506(b)(3)
    - Necessary
      - Administration proper and efficient: 474(a)(3); 1603(a)(4)*
      - Administration proper and official: 1403(a)(3)
      - Administrative provisions: 1616(b)(2); 1631(g)(4)(B)
      - Conditions for payment to State: 426(c)
      - Contract terms: 1876(i)(3)(D)
      - Criteria for renal disease network areas: 1881(c)(1)(A)
      - Data; medicare supplemental policies: 1882(a)
      - Effective and efficient operation: 1861(o)(7)
      - Financial security measures: 1861(o)(7)
      - Health and safety conditions: 1861(s)(end), (cc)(2)(I)
      - Investigation: 455(b)(1); 1003(b)(1); 1603(b)(1)*
      - Mental retardation information: 1703
      - Nursing facility requirements: 1919(d)(4)(B)
      - Operation efficiency: 402(a)(5); 1003(a)(3)
      - Personnel methods: 1602(a)(5)*
      - Records; access and correctness: 1703
      - Report verification: 402(a)(6)
      - Requirements: 1861(dd)(2)(G)
      - Skilled nursing facility requirements: 1819(d)(4)(B)
      - State report provisions: 1002(a)(6); 1602(a)(6)*
      - Terms and Conditions
        - Agreement: 1816(c)(1)
        - Contract: 1842(b)(3)
      - Test conditions: 1861(s)(15)
    - Needed
      - Agreement with hospital: 1861(l)
      - Conditions for
        - Diagnostic tests: 1861(s)(3)
        - Furnishing physical therapy services: 1861(p)

- Secretary HHS; Authority and Duty (Cont.)
  - Find (Cont.)
    - Needed (Cont.)
      - Conditions for (Cont.)
        - Health and safety: 1861(p)(4)(A)(v), (p)(4)(B)
        - Items and services furnished hospital patient: 1861(s)
        - Participation: 1861(o)(6); 1864(a)
      - Recommendations for legislative change: 1881(f)(8)
      - Records to determine degree and intensity of treatment: 1861(f)(3)
      - Requirements
        - Health and safety: 1861(e)(9)
        - Rural health clinic: 1861(aa)(2)(K)
      - Staffing requirements: 1861(f)(4)
    - Nonrenewal reason removed: 1866(c)(1)
    - Nursing facility deficient: 1919(h)(2)(A)
    - Onsite inspections: 1903(g)(4)(B)
    - Organization has failed to perform: 1881(c)(1)(A)
    - Organization or publication that serves purpose: 1873
    - Overpayment: 204(a)(1)
    - Patient capability: 1881(b)(1)(C)
    - Payment amount: 1631(b)(1)(A)
    - Payment period: 1879(a)
    - Physician qualified: 1861(s)(12)
    - Rates reasonably related to State analyses: 1861(v)(1)(E)
    - Reduction period: 224(b)
    - Reporting failure: 1631(b)(4)
    - Review failure: 1866(d)
    - Signature on request impracticable: 1814(a)(1); 1835(a)(1)
    - Standards essentially equal to JCAH: 1861(e)
    - State
      - Child support program ineffectiveness: 403(h)
      - Code adequate: 1819(d)(2)(B)(ii); 1919(d)(2)(B)(ii)
      - Compliance failure: 508(b)
      - Consultative service satisfactory: 1864(a)
      - Disability determinations faulty: 221(a)
      - Performance Does Not Meet
        - Plan provision requirement: 471(b)
        - Plan requirement: 4; 404(a); 471(b); 1004; 1116(a)(2); 1404; 1604*; 1904
    - Termination reason removed: 1866(c)(1), (d)
    - Underpayment: 204(a)(1)

- Secretary HHS; Authority and Duty (Cont.)
  - Find (Cont.)
    - Utilization review; assistance: 1816(b)(1)(B)
    - Waiver conditions met: 1861(e)(5)
    - World War II veteran; allied armed forces: 217(h)(1)
  - Fix
    - PRRB compensation rate: 1878(h)
    - Reallotment date: 424
    - State payment due date: 403(b)(3); 1003(b)(3)
  - Furnish
    - Explanation to providers: 1816(e)(3)
    - Information to Managing Trustee: 1817(f)(1)
    - Information to National Commission on Children: 1139(h)
    - Opportunity for Hearing to
      - Individual: 1869(b)(1)
      - Institution or agency: 1866(h)
      - Provider: 1816(e)(3)(A); 1866(d)
      - Provider; class: 1816(e)(3)(B)
    - Report to peer review organization: 1153(h)(3)
    - Technical assistance: 467(c)
  - Give priority to projects serving most needy areas: 426(b)(4)
  - Grant
    - Exception; physician charges: 1887(a)(2)(C)
    - Extension of time; annual report: 203(h)(1)(A)
    - Funds for research, training, or demonstration projects: 426
    - Waiver: 1915(d)
  - Hear; Hearing
    - Carrier; contract termination: 1842(b)(5)
    - Claimant
      - Application: 205(b)(1)
      - Disability determination: 221(d)
      - Earnings record: 205(c)(7)
      - Entitlement and benefits; medicare: 1869(b)(1)
      - SSI claim: 1631(c)(1)
    - Claimant's representative: 206(a)(1); 1631(d)(2)
    - Hospital; transitional allowance: 1884(d)
    - Intermediate care facility: 1910(b)(2)
    - Person: 1156(b)(4)
    - Practitioner: 1156(b)(4)
    - Provider of Services
      - Designation: 1816(e)(3)(B)
      - Failure of performance: 1816(g)(2)
      - Institution or agency: 1866(h)
    - Skilled nursing facility: 1910(b)(2)

- Secretary HHS; Authority and Duty (Cont.)
  - Hear; Hearing (Cont.)
    - State
      - Federal payment: 4; 404(a); 1004; 1116(a)(2); 1404; 1604*; 1904
      - Grant funds: 506(b)(2), (b)(3)
      - Performance failure: 471(b)
  - Hold or use payments for Indian Health Service: 1880(c)
  - Identify
    - Methods to assist review organizations: 1154(f)
    - Surgical procedures to be reviewed: 1164(b)(2)(A)
  - Implement
    - Appeals procedures: 1846(b)(1)(A); 1891(f)(1)
    - Overpayment procedures: 203(h)(4)
    - Report review procedures: 205(j)(3)(A); 1631(a)(2)(C)(i)
    - Sanction procedures: 1846(b)(3); 1891(f)(1)
    - Sanctions: 1846(b); 1891(f)(1)
  - Impose
    - Penalty: 1140(b); 1919(h)(3)(C)(ii); 1927(b)(3); 1930(h)(2)
    - Remedies: 1919(h)(3)(A)
    - Requirements: 1863
    - Sanctions: 1846(a); 1881(c)(3); 1891(e)(2)
    - Timetable for mechanization: 1903(r)(7)(B)
  - Improve data exchange: 1903(r)(6)(H)(iii)
  - Include contract standards: 1153(c)(7)
  - Incorporate dialysis supplies protocols in requirements for facilities: 1881(f)(7)
  - Increase
    - Benefits; cost-of-living: 215(i)(2)(A)(ii)
    - Hospital costs: 1886(d)(5)(D)(v)
    - Monthly premium rate: 1839(a)(3)(B)
    - Rate for payment of costs: 1861(v)(1)(E)
    - Specialty board eligibility period: 1886(h)(5)(G)(iii)(I)
  - Incumbency change; court appeal unaffected: 205(g)
  - Indemnify individual for payment to provider: 1879(b)
  - Independence; review limited: 205(h)
  - Inform Attorney General of person's past-due obligation: 1892(a)(2)(C)(i), (a)(3)(A)
  - Inform; earnings record data: 205(c)(2)(A)
  - Initiate
    - Penalty proceeding: 1128A(c)(1)

- Secretary HHS; Authority and Duty (Cont.)
  - Initiate (Cont.)
    - Pilot project for financial assistance: 1881(f)(1)
  - Insure flexibility of systems review procedures and standards: 1903(r)(6)(D)
  - Integrate activities with Public Health Service: 1903(m)(1)(B)
  - Investigate
    - Amount payable quarterly to State: 403(b)(1)
    - SSI beneficiary whereabouts and eligibility: 1631(i)(4)
  - Issue
    - Actuarial assumptions and bases;: 1818(d)(3); 1839(a)(3)
    - Appeal decision: 1886(d)(10)(C)
    - Regulations
      - Health care coverage: 452(f)
      - Limit reasonable costs: 1861(v)(1)(K)(i)
      - Limits, reasonable charge: 1842(b)(3)(end)
      - Nursing facility patient funds: 1919(f)(7)
      - Skilled nursing facility resident funds: 1819(f)(7)
    - Social security card: 205(c)(2)(F)
    - Subpena: 205(d); 1631(d)(1); 1918
  - Judge
    - Peer review ability: 1152(2)
    - State
      - Compliance: 404(c)
      - System: 1886(c)(4)(end)
    - Uniformity of medical services, supplies and equipment: 1842(b)(3)
  - Justification for work deductions: 203(h)(3)
  - Limit; payment adjustments: 1902(h)
  - Limit; regional agencies or organizations: 1816(e)(4)
  - Maintain earnings records: 205(c)(2)(A); 1817
  - Maintain hospital costs reporting system: 1886(f)(1)
  - Maintain representative payee file: 205(j)(3)(E)
  - Make
    - Adjustments in cost limits: 1888(c)
    - Adjustments in costs: 1888(a)(end)
    - Advance monthly payment: 1876(a)(1)(D)
    - Agreement with State; capital expenditures: 1122(b)
    - Arrangement with State; disability determinations: 1633(a)
    - Available
      - Accelerated payments: 1815(e)(3)
      - Grant to State: 1702
      - Information
        - To public: 1919(g)(5)(A)
- Secretary HHS; Authority and Duty (Cont.)
  - Make (Cont.)
    - Available (Cont.)
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END